INITIAL COMMENTS

During the annual recertification survey and complaint investigations number 27983 and 27822, conducted June 13-June 15, 2011, at Summit View of Lake City, no deficiencies were cited for complaints #27983 and #27822 under 42 CFR PART 482.13, Requirements for Long Term Care.

F 161

1. The surety bond amount was increased to $25,000 on 06/16/2011 to assure security of resident trust funds.
2. The resident trust account was reviewed on 6/15/2011 by the Business Office Manager and the Administrator to identify any other accounts that would be affected. The resident trust account will be reviewed weekly by the Business Office Manager or designee to assure compliance with state and federal regulations.
3. The surety bond has been increased to $25,000 dollars to assure compliance with state and federal regulations. The balance of the resident trust account will be monitored weekly for compliance by the Business Office Manager or designee.
4. The above practice will be reviewed monthly for 3 months during our Quality Assurance and Quality Improvement Meeting. If compliance is not met the practice will be revisited to ensure compliance with state and federal regulations.

LAWYER DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosedable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosedable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued program participation.
F 161 Continued From page 1
resident trust fund accounts up to $15,000.00.

Review of the resident trust fund bank account
statements for March, April, and May 2011,
revealed the account balance was between $25,
911.64 and $31,136.52 for the month of May
2011.

Interview with the Administrator on June 14,
2011, at 10:45 a.m., in the conference room,
confirmed the surety bond was insufficient to
cover the resident trust fund accounts for
twenty-nine of thirty-one days in May 2011.

F 176 483.10(n) RESIDENT SELF-ADMINISTER
DRUGS IF DEEMED SAFE

An individual resident may self-administer drugs if
the interdisciplinary team, as defined by
§483.20(d)(2)(i), has determined that this
practice is safe.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation,
policy review and interview, the facility failed to
assure one resident (#6) was assessed prior to
self administration of a medication of nineteen
residents reviewed.

The findings included:

Resident #6 was admitted to the facility on August
18, 2010, with diagnoses including Chronic
Obstructive Pulmonary Disease and
Hypertension.

Medical record review of the physician's
**SUMMIT VIEW OF LAKE CITY, LLC**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 176</td>
<td>Continued From page 2</td>
<td>recapitulation orders for June 2011, revealed a order for Pulmicort (maintenance treatment for asthma) nebulizer treatment - twice a day.</td>
<td>F 176</td>
<td>regulations.</td>
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<td>Observation of resident #8, in the resident's room, on June 13, 2011, from 8:15 a.m., to 9:30 a.m., revealed a nebulizer mask placed around the resident's mouth and the nebulizer machine was turned on and no nursing staff were present in the room.</td>
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<td>Review of the facility's Guidelines for Self-Administration of Drugs policy revealed &quot;...the staff and practitioner will assess each resident's mental and physical abilities to determine whether a resident is capable of self-administering medications...&quot;</td>
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<td>Interview with Licensed Practical Nurse #1 (responsible for the resident's medication) on June 13, 2011, at 9:30 a.m., at the nursing station, confirmed the resident had not been assessed for self administration of medications.</td>
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<td>F 221</td>
<td>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RERAINTS</td>
<td>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</td>
<td>F 221</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, interview, and a review of facility provided</td>
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</tbody>
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**STREET ADDRESS, CITY, STATE, ZIP CODE**
204 INDUSTRIAL PARK RD
LAKE CITY, TN 37769

**DATE SURVEY COMPLETED**
06/15/2011
Continued From page 3
documents, the facility failed to ensure one (#8) was free from physical restraints of twenty-five residents reviewed.

The findings included:

Medical record review revealed resident #8 was admitted to the facility on May 6, 2010, with diagnoses including Advanced Dementia and Coronary Artery Disease, and with a history of falls.

Medical record review revealed a physician's order, dated October 18, 2010, to use a seat belt alarm. Continued medical record review revealed no assessment of the resident's need for the seat belt as a restraint.

Observation on June 13, 2011, at 9:30 a.m., revealed resident #8 in the day room in a wheelchair with a self-release seat belt attached. Continued observation revealed when the Activity Assistant (also a certified nursing assistant) pointed to the seat belt and asked the resident to release the belt, the resident was unable to do so.

Interview on June 13, 2011, at 9:48 a.m., in the 400 hallway, with Licensed Practical Nurse #2 confirmed the seat belt was a physical restraint due to the resident's inability to release the belt when requested.

Interview with the Director of Nursing on June 13, 2011, at 3:15 p.m., in the conference room, confirmed the seat belt was a physical restraint, and an assessment of the need for the physical restraint was not completed prior to use of the seat belt.
**F 221** Continued From page 4

Review of facility provided documents revealed after resident #8 fell on December 8, 2010 (no injury), a physician's order was obtained for "Safety First Side rails applied to bed for prevention measure."

Observation of Registered Nurse (RN) #1 on June 14, 2011, at 10:20 a.m., in the empty resident's room, revealed the Safety First device was placed on the bed. Continued observation revealed RN #1 laid on the bed and attempted to "roll" out of the bed. Observation revealed the device prevented RN #1 from exiting the bed.

Interview with RN #1 on June 15, 2011, at 10:25 a.m., in the empty resident room, confirmed use of the Safety First device on the resident's bed, prohibited the resident's independent movement out of the bed.

Continued interview with RN #1 confirmed the resident had not been assessed for the use of the Safety First device prior to placement on the resident's bed.

**F 323**

483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced
**Statement of Deficiencies and Plan of Correction**

**(X4) ID Prefix Tag** | **Summary Statement of Deficiencies (Each Deficiency Must be Preceded by Full Regulatory or LEG Identifying Information)** | **(X5) Completion Date**
--- | --- | ---
F 323 | Continued From page 5 by: Based on medical record review, review of facility provided documents, observation, and interview, the facility failed to ensure one (#8) received adequate supervision to prevent falls of twenty-five residents reviewed. The findings included: Medical record review revealed resident #8 was admitted to the facility on May 6, 2010, with diagnoses including Coronary Artery Disease, Advanced Dementia, and Cardiomyopathy. Medical record review of the March 24, 2011, Minimum Data Set (MDS), revealed the resident was severely impaired for cognitive skills for daily decision making. Continued review of the MDS revealed the resident required extensive assistance for all activities of daily living (transfers, bathing, eating, personal hygiene, dressing, toileting), required physical assistance when transferring from bed to chair and chair to bed; and was wheelchair bound. Review of facility provided documents revealed the resident fell out of bed (low bed with mats) (no injury) on December 8, 2010, at 12:30 a.m., and a physician's order was obtained "Safety First Sidewall applied to bed for prevention measure." Review of facility provided documents revealed the resident fell out of bed (low bed with mats) (no injury) on December 11, 2010, at 6:40 a.m. (no injury), and the Safety First Sidewall was not attached to the bed, as per physician's order. Review of facility provided documents revealed Administrator on 06/20/2011 and 06/27/2011. 4. The above practice will be reviewed weekly for 4 weeks randomly for compliance by the DON of designee and monthly for 3 months in our Quality Assurance and Quality Improvement Meeting. If compliance is not met the practice will be revisited to ensure compliance with state and federal regulations. This practice will also be monitored by Safety/Fall Committee weekly for 3 months.

**SUMMIT VIEW OF LAKE CITY, LLC**

**Street Address, City, State, Zip Code**

204 Industrial Park Rd

LAKE CITY, TN 37769
<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>(X9) COMPLETION DATE</th>
</tr>
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<tbody>
<tr>
<td>F 323</td>
<td>Continued From page 6 the resident fell out of bed (low bed with mats) (no injury) on December 17, 2010, at 8:45 a.m., with the Safety First Siderail on the bed, and staff failed to ensure the bed rail was in locked position. Review of staff training records revealed the nursing staff were not trained on use of the Safety First Siderail until December 21, 2010, after the resident fell out of bed due to improper application of the side rail. Review of the manufacturer's instructions for use of the Safety First Siderail revealed the side rail could not be moved from the up to down position to exit the bed; was completely covered with netting and was intended to be used for children two years of age and older. Continued review of manufacturer's instructions revealed &quot;The bed rails are designed to remind the child they are getting close to the edge and to roll back to the center of the bed.&quot; Continued review of the manufacturer's instructions revealed &quot;Use only on an adult mattress with mattress and box spring.&quot; Continued review of the manufacturer's instructions revealed the Safety First Siderail was not to be used until the bed rail was observed to be locked in place. Observation of Registered Nurse (RN) #1 on June 15, 2011, at 10:20 a.m., in an empty resident room, revealed the Safety First Siderail was placed on the bed. Continued observation revealed the residents bed had only a mattress, with no box springs. Continued observation revealed RN #1 laid on the bed and attempted to &quot;roll&quot; out of the bed. Observation revealed the device did not allow RN #1 to exit the bed.</td>
<td>F 323</td>
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F 323. Continued From page 7

Interview with RN #2 on June 15, 2011, at 10:25 a.m., in the empty resident room, confirmed the Safety First Siderail was not utilized according to manufacturer's instructions on December 17, 2010, when the resident fell out of the bed, and confirmed nursing staff were not inservice on use of the side rail prior to the fall on December 17, 2010.

F 514

483.75(1) RES
RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, the facility failed to ensure the medical record was accurate for the code status for one (1) of twenty-five residents reviewed.

The findings included:

Resident #8 was admitted to the facility on May 6, 2010, with diagnoses including Coronary Artery

F 514.
1. The Medical record of Resident #8 was corrected on 6/14/2011 by the attending nurse to accurately reflect the correct code status of the resident.
2. The Code status of all residents will be reviewed by the Interdisciplinary Care Plan Team to assure physician's orders and the recapaulation orders are accurate by 7/22/2011.
3. There was an in-service conducted for the Licensed staff on 6/27/2011 by the MDS Department on Accuracy of Medical Records regarding code status and physician orders.
4. The above practice will be reviewed weekly for 4 weeks randomly for compliance by the Director of Nursing or designee, and monthly for 3 months in our Quality Assurance and Quality Improvement Meeting. If compliance is not met the practice will be revisited to ensure compliance with state and federal regulations.
F 514 Continued From page 8

Disease and Cardiomyopathy.

Medical record review of the POST (Physician's Orders for Scope of Treatment), dated May 11, 2010, revealed the resident was "Full Code" status (resident to be resuscitated if the heart stops).

Medical record review of the "Physician's Recapitulation Orders" for April, May, and June, 2011, revealed an order for "DNR" (Do Not Resuscitate).

Interview with the Director of Nursing on June 13, 2011, at 3:00 p.m., in the conference room, confirmed the resident's code status was "Full Code", and the Physician's Recapitulation Orders for April, May and June, 2011, were inaccurate.