483.10(b)(11) NOTIFY OF CHANGES
(INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, the facility failed to notify the...
Continued From page 1
physician of failure to administer medications for one resident (#7) of twenty-two residents reviewed.

The findings included:

Resident #7 was admitted on September 2, 2009, with diagnosis including Chronic Pain, Opioid Chemical Dependency, Anxiety, Depression, Spinal Stenosis, Torticollis (stiff neck with muscle contractions), Hypertension, and Mononeuropathy (inflammation of nerves).

Medical record review of the Minimum Data Set (MDS) dated May 22, 2011, revealed the resident had no memory or cognitive impairments, was on a scheduled pain regimen, received PRN (as needed) pain medications, and experienced frequent moderate pain that limited day to day activities.

Medical record review of a physician’s order dated August 3, 2011, revealed, Morphine Sulfate (narcotic for pain) SR (sustained release) 60mg every eight hours.

Medical record review of the nurse’s notes dated August 5 and 6, 2011, revealed the resident complained of pain and was requesting pain medications on August 5, at 2:00 p.m., August 6, at 2:00 p.m., and August 7, 2011, at 9:30 a.m., 12:00 p.m., 12:30 p.m., and 1:00 p.m.

Medical record review of the nurse’s notes dated August 6, 2011, at 12:45 p.m., revealed, the resident had a fall, refused to be evaluated at the Emergency Room (ER) and "...MD notified new
| F 157 | Continued From page 2 
orders given..." Medical record review of the 
physician's order revealed an order to change 
Morphine to 30mg. every six hours, with no date 
or time on the order. 

Medical record review of the Medication Record 
dated August 2011, revealed the resident 
received Morphine 60 mg. on August 5, 2011, at 
10:00 p.m., and did not receive the Morphine 
doses scheduled for August 6, 2011, at 6:00 
am., 2:00 p.m., 9:00 p.m., or August 7, 2011, at 
3:00 a.m., and 9:00 a.m. 

Telephone interview with the physician on August 
8, 2011, at 2:30 p.m., confirmed the physician 
was notified of the resident's fall, but was 
unaware the resident did not receive the 
scheduled pain medications as ordered on 
August 6 and 7, 2011. 

Interview with LPN #2 on August 8, 2011, at 3:00 
p.m., in the Staff Development Office, confirmed 
the resident did not receive the scheduled 
Morphine on August 6 or 7, 2011, due to nursing 
concerns regarding safety of administering pain 
medications after the fall and over sedation. 
Continued interview confirmed the physician was 
not notified the resident did not receive the 
scheduled pain medications. 

F 158 | 483.10(c)(2)-(5) FACILITY MANAGEMENT OF 
PERSONAL FUNDS 

Upon written authorization of a resident, the 
facility must hold, safeguard, manage, and 
account for the personal funds of the resident 
deposited with the facility, as specified in 
paragraphs (c)(3)-(8) of this section. 

F 159 | F 157-D cont. 
notification in event controlled medication 
for pain is with held, to ensure the physician/ 
NP is aware. This education will be com-
pleted by September 12, 2011. 

How the corrective actions will be moni-
tored to ensure the deficient practice will 
not recur; i.e., what quality assurance 
program will be put into place. 

One time per week audits were done for the 
Those residents who had routinely ordered 
controlled substance pain medication with 
held had documentation that the NP was nor-
tified. 

Beginning September 1, 2011, medication 
administration records will be audited daily 
(Monday-Friday) by the ADON/ designee to 
assure physician/NP was notified in event 
pain medication was with held. This audit 
will be done for 4 weeks, then three times per 
week for 2 months and monthly thereafter. 
Any issues identified will be addressed im-
mediately. 

The findings of these audits will be reviewed 
at the Performance Improvement Committee 
monthly for three months and quarterly 
thereafter. This committee will discuss and 
make any necessary revisions or recommenda-
tions. 

The Performance Improvement Committee 
consists of: at minimum, the administrator, 
medical director, director of nursing, social 
services director, and maintenance director. 
Date of compliance—September 16, 2011. 

9-16-11
### F 159

**Continued From page 3**

The facility must deposit any resident's personal funds in excess of $50 in an interest-bearing account that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

The facility must establish and maintain a system that assures a full and complete separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.
### F 159

Continued From page 4

This REQUIREMENT is not met as evidenced by:

- Based on review of resident trust account, facility policy review, and interview, the facility failed to notify the responsible party when the balance of the resident trust account was within $200.00 of the SSI (Social Security Income) resource limit ($2000.00) for one (#12) of fifty-five resident trust fund accounts reviewed.

The findings included:

- Review of resident #12's trust fund account revealed the following balances: on June 3, 2011=$2266.85; on July 1, 2011=$2316.93; and on August 3, 2011=$2361.05.

- Review of the facility's policy Resident Accounts revealed "...a resident on medical assistance must be notified whenever their funds are within $200 of their resource asset limit..."

- Interview on August 8, 2011, at 8:55 a.m., with the Business Office Manager and the Receptionist, in the office, confirmed the resident/resident's responsible party had not been notified the resident's trust fund account was within $200.00 of the SSI resource limit until last week (the first week of August 2011).

### F 201

**SS=D**

**483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT**

The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the

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**F 159-D cont.**

How the corrective actions will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

- The administrator will do a 100% audit of trust fund accounts by the 20th of each month to assure accuracy of accounts and appropriate notifications have occurred.

- The regional Business Office Manager's consultant will review the audits during scheduled visits.

The findings of these audits will be reviewed at the Performance Improvement Committee monthly for three months and then quarterly thereafter. This committee will discuss and make any necessary revisions or recommendations.

- The Performance Improvement Committee consists of, at minimum, the administrator, medical director, director of nursing, social services director, and maintenance director.

Date of compliance—September 16, 2011

**F 201-D**

What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?

- Facility Interdisciplinary Team made decision to initiate an emergent discharge of resident #7 to ensure the safety and well-being of this resident and other residents. The facility made attempts to help the local hospital find appropriate placement and placement was obtained.
Continued From page 5

facility;

The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

The safety of individuals in the facility is endangered;

The health of individuals in the facility would otherwise be endangered;

The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or

The facility ceases to operate.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, the facility failed to ensure a resident was not involuntarily discharged for one resident (#7) of twenty-two residents reviewed.

The findings included:

Resident #7 was admitted on September 2, 2009, with diagnosis including Chronic Pain, Opioid Chemical Dependency, Anxiety, Depression, Spinal Stenosis, Torticollis (stiff neck with muscle contractions), Hypertension, and Mononeuritis
F 201 Continued From page 8
(inflammation of nerves).

Medical record review of the Nurse's Notes dated August 7, 2011, at 9:45 p.m., revealed "...IDT (Interdisciplinary Team) decision to not take the resident back off (due to)...threatening, aggressive behaviors toward others and (self) by not allowing nursing staff to provide...treatment and overall care and meds ..."

Interview with the Social Services Director on August 8, 2011, at 8:00 a.m., in the Social Services Office, confirmed no documentation the resident had threatened self or other residents and the Director had not received any verbal reports from staff the resident was a danger to self or others. Further interview confirmed the resident had exhibited escalating behaviors the past two weeks and the facility had not attempted psychiatric intervention or counseling.

Interview with the Administrator on August 9, 2011, in Administrator's office, at 1:50 p.m., confirmed the resident had been discharged; a decision had been made to not allow the resident to return to the facility, the resident had exhibited escalating behaviors with no attempts by the facility to obtain psychiatric/psychological consults; and there was no documentation of the resident being a threat to self or others.

F 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4)
INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide

F 201 cont.
cause harm to the resident or others by September 12, 2011. Content to include appropriate interventions including psychiatric/psychological consultations and documentation of the resident being a threat to self and/or others prior to initiating the Emergency Discharges/Transfer Process.

How the corrective actions will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. A log will be kept by the social services director to track the offer of services, acceptance or declination of services, including date offered, date of initial visit by the provider, and if applicable, date discharged from psych caseload. The administrator will review the log weekly 4x4 weeks and monthly thereafter.

This psychiatric services referral log will be reviewed at monthly Performance Improvement committee meeting to ensure compliance with the process. An audit of discharges will be completed monthly by the Social Services Director to ensure that all discharges have followed the proper discharge/transfer process. The findings will be reviewed by the Performance Improvement Committee monthly for three months and quarterly thereafter.

The Performance Improvement committee consists of, at a minimum, the administrator, medical director, director of nursing, social work services director and maintenance director.

Date of compliance—September 16, 2011
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX 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 TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F225</td>
<td></td>
<td>Continued From page 7 registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</td>
<td>F225-D</td>
<td></td>
<td>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</td>
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<td>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</td>
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<td>Resident #8 was assessed by the wound nurses for bruises on August 11, 2011.</td>
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<td>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</td>
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<td>How do you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken?</td>
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<td>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</td>
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<td>All residents have the potential to be affected. 100% of residents have been assessed by the LPN wound nurses between August 11, 2011 and August 18, 2011. Any observed changes including bruises are investigated for cause and documented on the investigation report.</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to investigate an injury of unknown cause, for one (#8) of twenty-two residents reviewed.</td>
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<td>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.</td>
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<td>The LPN staff nurse who failed to investigate for the cause of the bruising received 1:1 education and counseling by the Director of Nursing on August 23, 2011, concerning the importance of a full investigation and determination of cause of any injury, including bruises.</td>
<td></td>
<td></td>
<td>The LPN staff nurse who failed to investigate for the cause of the bruising received 1:1 education and counseling by the Director of Nursing on August 23, 2011, concerning the importance of a full investigation and determination of cause of any injury, including bruises.</td>
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Continued From page 8

The findings included:

 Resident #8 was admitted to the facility on June 26, 2002 with diagnoses including Alzheimer's disease, Diabetes Mellitus II, Sanile Delusions, Hypertension, and BiPolar Disorder.

Medical record review of the Minimum Data Set (MDS) dated May 28, 2011, revealed the resident had difficulty with long and short term memory, and severe difficulty with decision making skills.

Continued review of the MDS revealed the resident required assistance with all activities of daily living, was non ambulatory, and incontinent of bowel and bladder.

Review of facility documentation revealed on December 2, 2010, the resident sustained bruises on the left inner thigh, the lower left leg, and the left lower abdominal area. Continued review of the facility documentation revealed no documentation for the time of day discovered, the description of the bruises, the sizes of the bruises, and no investigation was provided to determine the cause of the bruises.

Interview with the Interim Director of Nursing on August 8, 2011, at 8:00 a.m., in the Chapel, confirmed the bruises of unknown origin had not been investigated to determine the cause of the bruises.

Licensed nurses will receive in-service education regarding thorough investigation of injuries, including bruises by the Staff Development Coordinator or designee by September 12, 2011. Staff LPNs and RNs are responsible to fully investigate the cause of bruises.

Incident investigations are reviewed the next business day by the clinical team to ensure causes of any injury, including bruises, has been determined. The clinical team, which meets Monday-Friday (excluding holidays), is comprised of the director of nursing, assistant directors of nursing, MDS coordinators, Rehabilitative Services manager, Social Worker Services director, and Restorative Nurse manager.

Investigations of bruising will be reviewed at an additional weekly audit for 4 weeks to ensure root cause has been identified, then every two weeks and monthly thereafter.

How the corrective actions will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

Results of investigations involving bruising will be reviewed at the monthly Performance Improvement meeting. This review will include any issues regarding failure to thoroughly investigate cause of bruises monthly for three months and then quarterly thereafter.

The Performance Improvement Committee consists of, at a minimum, the administrator,
Continued From page 9 well-being of each resident.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation, and interview, the facility failed to provide medically-related social services for one resident with behaviors (7) of twenty-two residents reviewed.

The findings included:

Resident #7 was admitted on September 2, 2009, with diagnosis including Chronic Pain, Opioid Chemical Dependency, Anxiety, Depression, Spinal Stenosis, Torticollis (stiff neck with muscle contractions), Hypertension, and Mononeuritis (inflammation of nerves).

Medical record review of the Minimum Data Set dated May 22, 2011, revealed the resident had no memory or cognitive impairments, no behavior exhibited, and had diagnoses of Anxiety Disorder and Depression and received antipsychotic, anti-anxiety, and antidepressant medications.

Medical record review of the Physician's Orders dated May through August 2011, revealed no order for Psychiatric Services.

Medical record review of the Comprehensive Care Plan dated May 23, 2011, revealed a problem of "...Resident displays persistent anger with self and others, repetitive health/anxious concerns, and verbally abusive with staff...psychological/psychiatric consult..."

Observation on August 7, 2011, at 12:52 p.m., revealed the resident in a wheelchair, yelling at another resident. Continued observation revealed the resident opened the door at the Nurses Station and attempted to get self-propelled. Observation revealed several other staff members came to the Nurses Station and attempted to redirect the resident. Continued observation revealed the resident continued to have an increase in anger, had verbally abusive behaviors toward other staff, requesting pain medications, and was sent to the emergency room for escalating behaviors at 1:30 p.m.

Interview with the Social Services Director August 9, 2011, at 8:00 a.m., in the Social Services Office revealed the staff had reported the resident's "...abusive and threatening behaviors toward staff increased in the past two weeks..." and confirmed the Social Services Director had not referred the resident for psychological/psychiatric consultation.

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and emotional well-being.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.

The social worker will be responsible to obtain the signed consent for psychiatric services and request a signed order be obtained from the physician or NP. The social worker is responsible to notify the psychiatric services provider of the need for services.

A log book will be kept by the social worker to track the offer of services, acceptance or declination of services, including date offered, date of initial visit by the provider, and if applicable, date discharged from psych caseload. The administrator will review the log weekly X4 weeks and monthly thereafter.

How the corrective actions will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

This log will be reviewed and discussed at monthly Performance Improvement Committee to make any necessary revisions or recommendations to ensure compliance with the process for three months and then quarterly thereafter.

The Performance Improvement Committee consists of the administrator, medical director, director of nursing, social services director, and maintenance director.

Date of compliance—September 16, 2011
### F 309
Continued From page 11

mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation, and interview, the facility failed to manage pain for one resident (#7) of twenty-two residents reviewed.

The findings included:

Resident #7 was admitted on September 2, 2009, with diagnosis including Chronic Pain, Opioid Chemical Dependency, Anxiety, Depression, Spinal Stenosis, Torticollis (stiff neck with muscle contractions), Hypertension, and Mononeuritis (inflammation of nerves).

Medical record review of the Minimum Data Set (MDS) dated May 22, 2011, revealed the resident had no memory or cognitive impairments, was on a scheduled pain regimen, received PRN (as needed) pain medications, and experienced frequent moderate pain that limited day to day activities.

Medical record review of a physician’s order dated July 15, 2011, Oxycodone (narcotic for pain) 15mg. (milligrams) every six hours PRN.

Medical record review of a physician’s order dated August 3, 2011, revealed, Morphine Sulfate (narcotic for pain) SR (sustained release) 60mg every eight hours.

### F 309-D
What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?

Resident #7 no longer resides in the facility

How do you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken?

Residents with routine orders for controlled medication for pain have the potential to be affected. Those with controlled substances ordered routinely for pain management were reviewed on 8/10/2011. None had documentation of medication having been with held since the survey.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.

RN #2 received informal 1:1 education and counseling by the DON and SDC on August 9, 2011 and again on August 23, 2011 by the DON on the importance of physician/NP notification if pain medication has been withheld, along with documentation of the notification and professional nursing rationale for with holding the medication.
### F 309

Continued From page 12

Medical record review of the Nurse's Notes dated August 5 and 6, 2011, revealed the resident complained of pain and was requesting pain medications on August 5, at 2:00 p.m., August 6, at 2:00 p.m., 6:00 p.m., and August 7, 2011, at 9:30 a.m., 12:00 p.m., 12:30 p.m., and 1:00 p.m.

Medical record review of the nurse's notes dated August 6, 2011, at 12:45 p.m., revealed the resident had a fall, refused to be evaluated at the Emergency Room (ER) and "...MD notified new orders given..." Medical record review of a physician's telephone order revealed an order to change Morphine to 30mg. every six hours, with no date or time on the order.

Medical record review of the Medication Record dated August 2011, revealed the resident received Morphine 60 mg. on August 5, 2011, at 10:00 p.m. and did not receive the Morphine doses scheduled for August 6, 2011, at 6:00 a.m., 2:00 p.m., 9:00 p.m., or August 7, 2011, at 3:00 a.m., and 9:00 a.m. Medical record review of the Medication Record dated August 2011, revealed the resident received one dose of the Oxycodone 15mg. PRN medication on August 6, 2011 at 6:00 p.m.

Observation on August 7, 2011, at 12:52 p.m., at the nurse's station revealed the resident in a wheel chair propelling self. Continued observation revealed the resident opened the door at the Nurse's Station, yelling loudly at Licensed Practical Nurse (LPN) #2, "I have dressed myself... (used restroom)... can I have my medicine now?" Continued observation revealed several staff members came to the Nurse's

### F 309-D cont.

All licensed nurses will receive in service education by the SDC, DON, or designee regarding the importance of physician/NP notification in event pain medication is withheld, to ensure the physician/NP is aware. This education will be completed by September 12, 2011.

How the corrective actions will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

Weekly reviews were done in August, 2011 after survey exit. Any with held controlled pain medication was documented on the MAR and noted to have NP notification.

Beginning September 1, 2011, medication administration records will be audited daily (Monday-Friday) by the ADONs/ designee to assure physician/NP was notified in event pain medication was withheld. This audit will be done for 4 weeks, then three times per week for 2 months. Any issues identified will be addressed immediately.

The findings of these audits will be reviewed at the Performance Improvement Committee monthly for three months and then quarterly thereafter. This committee will discuss and make any necessary revisions or recommendations.

The Performance Improvement committee consists of: at minimum, the administrator, medical director, director of nursing, social services director, and maintenance director.

Date of compliance—September 16, 2011
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<th>(X2) MULTIPLE CONSTRUCTION</th>
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<tr>
<td>445382</td>
<td>A. BUILDING</td>
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<td>B. WING</td>
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</table>

**NAME OF PROVIDER OR SUPPLIER**
PIGEON FORGE CARE & REHAB CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**
415 COLE DRIVE
PIGEON FORGE, TN 37863

**DATE SURVEY COMPLETED**
08/09/2011

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<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
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<tr>
<td>F 309</td>
<td>Continued from page 13</td>
<td>F 309</td>
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<td>Station and attempted to redirect the resident. Continued observation revealed the resident continued to have an increase in anger and verbally abusive toward staff, requesting pain medications, and was sent to the (ER) for escalating behaviors at 1:30 p.m. Telephone interview with the physician on August 8, 2011, at 2:30 p.m., confirmed the physician was notified of the resident's fall, but was unaware the resident did not receive the scheduled pain medications as ordered on August 6 and 7, 2011. Interview with LPN #2 on August 8, 2011, at 3:00 p.m., in the Staff Development Office, confirmed the resident did not receive the scheduled Morphine on August 6 or 7, 2011, due to nursing concerns regarding safety of administering pain medications after the fall and over sedation. Continued interview confirmed the physician was not notified the resident did not receive the scheduled pain medications and was not consulted for additional orders for pain control. Continued interview confirmed the resident had been on scheduled narcotic pain medications for many years, was experiencing increased agitation, and demanding behaviors which might have been related to withdrawal of pain medications. Interviews with the physician on August 8, 2011 at 2:30 p.m., by telephone, LPN #2 at 3:00 p.m., in the Staff Development Office, and with Nurse Practitioner #1 on August 9, 2011 at 10:35 a.m., in the Staff Development Office confirmed the resident's pain was not managed.</td>
<td>F 323</td>
<td>483.25(h) FREE OF ACCIDENT</td>
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Continued From page 14

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 by:
Based on medical record review, observation, and interview, the facility failed to maintain an environment free of hazards and failed to ensure a safety device was functional for one resident (#10) of twenty-two residents reviewed.

The findings included:
Resident #10 was admitted to the facility July 30, 2003, with diagnoses including Atherosclerotic Cardiovascular Disease, Diabetes, Depression, and Chronic Obstructive Airway Disease.

Medical record review of the Minimum Data Set (MDS) dated June 23, 2011, revealed the resident had severe cognitive impairment and required staff supervision and physical assistance with transfers and ambulation.

Medical record review of the resident's care plan dated June 27, 2011, revealed "...at risk for fall related injury R/T (related to) hx (history) of falls...staff to assist with ambulation and/or locomotion as needed...door alarm to bathroom door..." Further medical record review of the

What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?

The bed wheels for resident #10, were locked immediately on 6/4/11; the bathroom door alarm was replaced immediately on July 1, 2011.

How do you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken?
Residents' beds with unlocked wheels/malfunctioning wheel locks have the potential to be affected. Housekeeping Supervisor completed a 100% audit on August 9, 2011 of all bed locks to determine if locked or if they worked appropriately. Identified issues were immediately corrected.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.

Housekeeping staff was in-serviced by the housekeeping supervisor on August 17, 2011, to check bed wheels to ensure bed wheels are locked as part of their daily routine of assigned rooms.

Facility staff were in-serviced by Staff Development Coordinator on August 30 and August 31, 2011 on the importance of checking that bed wheels are locked as part of daily routine.
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<th>ID PREFIX TAG</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>F 323</td>
<td>Continued From page 15, resident's care plan revealed &quot;...res (resident) requires assistance with ADLs (activities of daily living) R/T decreased safety awareness...&quot;</td>
<td>F 323-D cont.</td>
<td>Housekeeping staff started daily audits of bed wheels locks on 8/23/2011. Any unlocked wheels were immediately locked. The housekeeping supervisor began 100% audit two times per week on 8/23/2011. This was increased to three times per week on 9/1/2011. Any wheels observed to be unlocked were immediately locked. Follow up to the ADON or charge nurse for follow up with nursing staff.</td>
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<td>F 372</td>
<td>483.35(R)(3) DISPOSE GARBAGE &amp; REFUSE PROPERLY</td>
<td>F 372</td>
<td>Nursing staff began receiving in-service education by the Staff Development Coordinator on August 30, 2011 on the importance of functioning bathroom door alarms. This will be completed by September 12, 2011. Door alarm checks are part of licensed nurse responsibility throughout their shift. Extra alarms and batteries are readily available at the nurses station in the event an alarm malfunctions. The ADONS or designee will monitor door alarm functioning daily for two weeks, then three times a week for two weeks, and weekly thereafter for two months. Results will be documented on an audit tool.</td>
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How the corrective actions will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

Results of these audits will be reviewed by the Performance Improvement Committee monthly for three months and quarterly thereafter. The committee will discuss and make any necessary revisions or
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| F 372 | Continued From page 16  
The facility must dispose of garbage and refuse properly.  
This REQUIREMENT is not met as evidenced by:  
Based on observation, and interview, the facility failed to maintain the area around the facility dumpster in a clean and sanitary manner.  
The findings including:  
Observation of the dumpster area on August 7, 2011, at 10:00 a.m., with the Assistant Dietary Manager, revealed the following items stored behind two of the outside buildings with the dumpster between the buildings: Multiple abandoned shower and geri chairs; stacks of old used wood pieces; abandoned oxygen concentrator; open plastic pails filled with water; a white plastic tubular two shelf cart, with a tray at the bottom, filled with greenish colored water; an old, rusty, abandoned, deteriorated Jeep with jagged edges and no top; and other miscellaneous pieces of debris.  
Observation and interview with the Administrator on August 9, 2011, at 9:15 a.m., at the dumpster area, confirmed the above items and debris around the dumpster area.  
483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH  
The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State

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</table>
| F 372 | F 323—cont.  
recommendations. The Performance Improvement committee consists of, at a minimum, the administrator, medical director, director of nursing, social services director and maintenance director.  
Date of compliance—September 16, 2011  
F 372  
What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?  
On August 9, 2011 the abandoned stacks of shower and geri chairs, stacks of old used wood pieces, abandoned oxygen concentrator, open plastic pails filled with water, white plastic tubular two shelf cart with tray at bottom, and other miscellaneous pieces of debris were removed. The old rusty Jeep has been removed as of Sept 6, 2011.  
How do you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken?  
Facility resident have the potential to be affected by this deficient practice. Environmental Rounds were completed on August 9, 2011 by the Maintenance Supervisor.  
F 425  
What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.  
Maintenance staff were in-serviced by the
F 425 Continued From page 17

law permits, but only under the general supervision of a licensed nurse.

A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, the facility failed to provide pharmaceutical services in a timely manner for one resident (#7) of twenty-two residents reviewed.

The findings included:

Resident #7 was admitted on September 2, 2009, with diagnosis including Chronic Pain, Opioid Chemical Dependency, Anxiety, Depression, Spinal Stenosis, Torticollis (stiff neck with muscle contractions), Hypertension, and Mononeuropathy (inflammation of nerves).

Medical Record review of a telephone order dated August 3, 2011, at 6:00 p.m., revealed, Ativan 0.5 mg. BID (twice daily) and Ativan 1 mg. HS (nightly).

F 425-D cont.

To prevent the improper maintenance of the area around the facility dumpster to maintain a clean and sanitary environment, the administrator or Maintenance Director will complete a weekly inspection to ensure the area is maintained in a clean and sanitary manner for four weeks and then monthly thereafter.

How the corrective actions will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

Maintenance will do a monthly environmental rounds audit of the dumpster area for three months reporting findings to the monthly Performance Improvement Committee. If there are no additional findings of non-compliance then the audit will be completed quarterly thereafter.

The Performance Improvement committee consists of, at a minimum, the administrator, medical director, director of nursing, social services director and maintenance director.

Date of compliance—September 16, 2011

F 425-D

What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?

Resident #7 no longer resides at the facility.

How do you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken?
### Summary Statement of Deficiencies

**F 425** Continued From page 18  
Medical record review of the Medication Record dated August 2011, revealed the resident did not receive Ativan 0.5mg. on August 3, 2011, at 8:00 p.m., and August 4, 2011, at 8:00 a.m., and 4:00 p.m.

Medical record reviewed a telephone order dated August 4, 2011, "...OK to hold Ativan until available..."

Review of the Shipping Manifest from the facility’s pharmacy revealed the medication left the pharmacy on August 4, 2011, at 4:59 p.m., and arrived at the facility on August 4, 2011, time not documented.

Medical record review of the nurse's notes dated August 6, 2011, at 12:45 p.m., revealed, "...MD notified new orders give..." Medical record review of the physician's order revealed an order to change Morphine to 30mg. every six hours, with no date or time on the order.

Medical record review of the Medication Record dated August 2011, revealed, the resident did not receive Morphine 30mg. on August 6, 2011 at 8:00 p.m. Medical record review of the Nurse’s Notes dated August 6, 2011 at 8:00 p.m., revealed, the resident was told "...Morphine was being sent STAT from pharmacy..."

Medical record review of the Shipping Manifest from the facility’s Pharmacy revealed the medication left the pharmacy on August 6, 2011 at 9:12 p.m. and arrived at the facility on August 6, 2011, time not documented.

Interview with LPN #2 August 8, 2011, at 2:34

### Provider's Plan of Correction

**F 425-D**  
What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?  
Resident #7 no longer resides at the facility.

How do you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken?  
Residents with STAT orders for controlled substances from the pharmacy are identified. The pharmacy provides a notification to the facility when STAT orders are placed. The facility then orders the medication and monitors the supply and usage.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.

RN#2 has received informal 1:1 in service education and counseling on August 9, 2011 and again August 23, 2011 by the DON regarding the process for ordering STAT controlled substances from the pharmacy, including the processing time frame which per the pharmacy provider is at least 4 hours; correct interpretation of time line information on the shipping manifest; and the importance of documenting the time of receipt from pharmacy on the packing slip.  
This in service education included appropriate communication with the pharmacy and the physician/NP to ensure timely delivery of controlled substances.  
Licensed nurses will receive this same in service education by September 12, 2011 by the Staff Development Coordinator or designee.
F 425 Continued From page 19
p.m., in the Staff Development Office confirmed
"...an order to decrease Morphine was received
prior to resident being sent to ER on August 6,
2011 at 3:30 p.m."

Interviews with the Administrator, Staff
Development Coordinator, Corporate Nurse
Consultant, and LPN#2 on August 8, 2011, at 2:34
p.m., in the Staff Development Office, and with
Corporate Nurse Consultant on August 9, 2011,
at 1:45 p.m., in the Chapel, confirmed STAT was
to be delivered in two hours to facility, and the
facility failed to acquire medications in a timely
manner.

F 441 463.65 INFECTION CONTROL, PREVENT
SPREAD, LINENS

The facility must establish and maintain an
Infection Control Program designed to provide a
safe, sanitary and comfortable environment and
to help prevent the development and transmission
of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control
Program under which it-
(1) Investigates, controls, and prevents infections
in the facility;
(2) Decides what procedures, such as isolation,
should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective
actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program
determines that a resident needs isolation to
prevent the spread of infection, the facility must
isolate the resident.

F 426—cont.
In the event the resident has need of pain
management before the STAT medication is
anticipated to arrive, the nurse will again
contact the physician or NP and review medications
available in the emergency drug kit
that may be administered to provide a measure
of relief until the STAT medication arrives from the pharmacy. STAT orders for
controlled substances and any substitutes
will be reviewed by the clinical team during
daily clinical meeting (Monday-Friday) for
compliance. The clinical team consists of the
director of nursing, assistant directors of
nursing, MDS coordinators, Rehabs Services manager, social work services
director, and restorative nurse manager.

How the corrective actions will be monitored
to ensure the deficient practice will
not recur; i.e., what quality assurance program will be put into place.

ADONs will audit all STAT orders for con-
trolled substances Monday-Friday for 4
weeks, beginning September 1, 2011; two
times a week for 4 weeks; and weekly there-
after. The audits will be reviewed by the Performance
Improvement Committee monthly for
three months and then quarterly thereafter.
The Performance Improvement Committee
consists of, at a minimum, the administrator,
medical director, director of nursing, social
services director and maintenance director.

Data of compliance—September 16, 2011
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

| (X) PROVIDER/Supplier/Clinical Identification Number: | 445382 |

<table>
<thead>
<tr>
<th>(X) MULTIPLE CONSTRUCTION</th>
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<tbody>
<tr>
<td>A. BUILDING:</td>
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<td>B. WING:</td>
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<tr>
<th>(X) DATE SURVEY COMPLETED</th>
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<td>08/09/2011</td>
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**NAME OF PROVIDER OR SUPPLIER**

PIGEON FORGE CARE & REHAB CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

415 COLE DRIVE
PIGEON FORGE, TN 37863

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<tr>
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| F 441             | Continued From page 20  
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.  
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  
(c) Linens  
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  
This REQUIREMENT is not met as evidenced by:  
Based on observation, review of facility policy, and interview, the facility failed to follow the infection control policy for one staff member (Dietary Manager) who presented with a contagious infection.  
The findings included:  
Observation on August 7, 2011, at 9:20 a.m., revealed the Dietary Manager entered the dietary department wearing a mask (over the mouth and nose), having difficulty with speaking and clearing the throat. Interview with the Dietary Manager at the same time confirmed the Dietary Manager had been sick and had gone to the emergency room in the morning of August 7, 2011.  
Continued observation on August 7, 2011, at 10:05 a.m., in the conference room revealed the Dietary Manager moved a food tray from the |
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| F 441         | What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?  
The ill employee was sent home by the supervisor immediately on August 7, 2011.  
How do you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken?  
Residents who came into contact with or were served food by this dietary employee had the potential to be affected. No residents developed symptoms of “strept throat” as result of this contact or food service by the employee.  
This employee was educated on August 10, 2011 by the Director of Nursing regarding the symptoms of “strept throat” measures to prevent spread to others; and recommendations for physician consult and treatment as outlined in CDC educational information from the CDC website. The education also reviewed dietary infection control protocol, including prompt reporting to the supervisor if symptomatic; concomitant review by the infection control nurse or other nurse designee and the importance of use of protective barriers such as face masks to prevent possible infection. In addition the human resources policy was reviewed which further supports the dietary specific policy. |
F 441 Continued from page 21

Conference room to the chapel without the mask on the face. Continued observation on August 7, 2011, at 4:36 p.m., revealed the Dietary Manager walking down the hall toward and into the Dietary Department, without the mask on the face.

Observation on August 7, 2011 at 10:20 a.m., 10:30 a.m., 1:37 p.m., 2:10 p.m., 2:40 p.m., and 2:46 p.m., revealed the Dietary Manager, wearing the mask, at different areas of the nursing home including the main dining room, the dining room on the 200 hall, the chapel, and at the nurses' station on the 200 hall.

Interview with the Dietary Manager on August 7, 2011, at 2:46 p.m., in the Chapel, confirmed the visit to the emergency room resulted in a diagnosis of "Strep Throat" and received an antibiotic, prednisone, and Chloroceptic spray.

Review of the facility policy for Communicable & Contagious Diseases revealed, "...It is the policy of the company that Stakeholders with communicable or infectious disease(s) shall be restricted from providing direct nursing care or services to residents...Stakeholders who may have or develop symptoms (i.e., flu, pink eye shingles, strep throat, fever and others...or signs of a communicable or infectious disease(s)...must report such information to the Supervisor immediately."

Interview with the administrator on August 7, 2011, at 4:50 p.m., in the main lobby, confirmed the administrator was informed of the trip to the emergency room in the morning of August 7, 2011, by the Dietary Manager, and confirmed the Dietary Manager was wearing a mask.
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<td>Interview with the infection control nurse on August 7, 2011, at 4:50 p.m., in the main lobby, confirmed the facility failed to follow the infection control policy.</td>
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