

RECEIVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445470	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/13/2014
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NAME OF PROVIDER OR SUPPLIER BENCHMARK HEALTHCARE OF PURYEAR INC	STREET ADDRESS, CITY, STATE, ZIP CODE 220 COLLEGE STREET PURYEAR, TN 38251
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(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 160 483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH
SS=D

Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

This REQUIREMENT is not met as evidenced by:
Based on each review of resident rights, review of a transaction history, review of written check, medical record review and interview, it was determined the facility failed to refund to the deceased resident's estate the balance of the resident's account within 30 days for 1 of 2 (Resident #17) sampled residents of the 20 residents included in the stage 2 review.

The findings included:

Review of the resident rights documented, "...Conveyance upon death: Upon the death of a Resident with a personal fund deposited with the Facility, the Facility must convey within 30 days the Resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the Resident's estate..."

Medical record review for Resident #17 documented the resident expired on 6/13/14.

Review of a transaction history by effective date January 1, 2014 through present date documented, "...Resident Liability... 10/20/2014... REFUND... \$2,880,000..."

F 160

F 160-
Refund of Resident Liability for Resident #17 was made payable to the "Estate of" Resident #17 on 10/20/14.

A review of deceased residents, who expired in the last 180 days, was completed by the Business Office Manager on 11/18/2014, to identify any other deceased residents who did not receive a refund of their Resident Liability.

The Business Office Manager will complete and submit a "Resident Refund Request" to the billing department within 7 days of the death of a resident. The request shall be signed by both the Business Office Manager and the Administrator. The Business Office Manager will maintain a log regarding the status of resident refunds.

Any future noncompliance with Resident Refunds will be reported to the Quality Assurance/Improvement Committee by the Business Office Manager for immediate action to resolve the issue.

11-18-14

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

TITLE

(X6) DATE

K. Auerhast

LNHA

11-18-14

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 disclosable 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 disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 160 Continued From page 1
Review of a check dated 10/21/14 documented, "...PAY TO THE ORDER OF [Named Resident #17's Estate]..."

During an interview in the business office on 11/12/14 at 5:20 PM, the business office manager verified the refund was not done within 30 days as required.

During an interview in the conference room on 11/12/14 at 5:34 PM, the administrator verified the refund was not done within 30 days as required.

F 160

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP
SS=D

F 280

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

F 280- 11-25-14

The facility will ensure this resident has a current care plan with all new interventions documented appropriately and timely. Care plan of Resident #13 was updated on 11/17/2014.

The facility will ensure that all residents have a current care plan with all new orders and interventions documented appropriately and timely.

The Director of Nursing or her designee will review the current resident care plans for appropriate interventions regarding falls and timeliness of new orders and interventions. Licensed nursing staff will be in-serviced on the policy and procedure "Comprehensive Care Plan" and "Fall Strategies/Interventions" on 11/25/14 by the Director of Nursing.

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F 280	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on policy review, review of an incident report, medical record review and interview, it was determined the facility failed to update a care plan for a fall in a timely manner for 1 of 15 (Resident #13) sampled residents of the 20 residents included in the stage 2 review.</p> <p>The findings included:</p> <p>Review of the facility's "Comprehensive Care Plan" policy documented, "...d. Brief audit of medical record to ensure... i. fall interventions documented, appropriate and timely after each fall..."</p> <p>Medical record review for Resident #13 documented an admission date of 7/3/14 with a re-admission date of 8/8/14 with diagnoses of Disc Degeneration, Depression, Dementia, Muscle Weakness, Altered Mental Status, Abnormality of Gait, Angina, Scoliosis, Vertigo, Hypotension, Osteoporosis, Urinary Incontinence, Acute Myocardial Infarction, Hemolytic Anemia, Cerebral Ischemia, Osteoarthritis, Muscle Spasms and Delirium.</p> <p>Review of a facility incident report dated 10/14/14 documented Resident #13 was bending over reaching for a cell phone, lost her balance and fell. No injury was noted.</p> <p>Review of the Minimum Data Set (MDS) dated 11/4/14 documented 1 fall since last assessment with no injury.</p> <p>Review of a care plan dated 7/14/14 documented, "...potential for falls r/t [related to] decreased</p>	F 280	<p>Any future noncompliance in prompt documentation in care plans will be reported to the Quality Assurance/ Improvement Committee by the Director Of Nursing or MDS Coordinator for immediate action to resolve the issue.</p>	
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F 280	Continued From page 3 mobility..." The care plan updated on 10/29/14 documented, "...Keep... commonly used items in easy reach (cell phone, w/c [wheelchair]...) Keep... door open during waking hours so I can be checked on. PT [Physical Therapy] as ordered, Encourage me to participate. The care plan was updated 15 days after the fall. During an interview in the Director of Nursing's (DON's) office on 11/12/14 at 4:45 PM, the DON was asked if updating a care plan with interventions on 10/29/14 for a fall that occurred on 10/14/14 was acceptable. The DON stated, "No it is not."	F 280		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	F 431- All expired medications were removed from the medication refrigerator located in the medication room on 11/12/2014. All medications in the medication refrigerator, medication cabinet, and medication carts #1 & #2 were inspected for expired medication by licensed nursing staff on 11/17/2014. Any expired medications found on inspection were removed.	11-25-14

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F 431	<p>Continued From page 4</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure medications were not stored past their expiration date in 1 of 3 (medication room) medication storage areas.</p> <p>The findings included:</p> <p>Review of the facility's medication storage policy documented, "...No discontinued, outdated, or deteriorated medications should be available for use in the facility. All such medications are destroyed per policy. Expired medications are to be removed from areas medication carts prior to or at the time of expiration..."</p> <p>Observations in the medication room on 11/12/14 at 12:10 PM, revealed Acetaminophen Suppositories 650 milligrams (mgs) stored past the expiration date of 9/14, Lorazepam 0.5 milligrams (mgs) and Compazine 10 mg stored past the expiration date of 10/17/14.</p> <p>During an interview in the medication room on</p>	F 431	<p>A daily check of medications in the medication refrigerator, medication cabinet, and medication carts #1 & #2 will be completed by the night shift charge nurse every night. Compliance will be monitored by the Director of Nursing or her designee. All licensed nursing staff will be in-serviced on the policy regarding "Medication Expiration" on 11/25/2014.</p> <p>Any future noncompliance with disposal of expired medications will be reported to the Quality Assurance/Improvement Committee by the Director of Nursing for immediate action to resolve.</p>		

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F 431	Continued From page 5 11/14/14 at 12:15 PM, Nurse #1 verified Acetaminophen, Lorazepam and Compazine were stored past their expiration dates.	F 431		
F 441 SS=E	483.65 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. (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	F 441	F 441-	11-25-14

The facility implemented a "Trending and Tracking Infections" policy and procedure on 11/12/14 for the purpose of collecting information regarding infections related to the residents.

The Director of Nursing reviewed all Reports of infections and compiled Tracking and Trending information for October 2014. The "Infection Control Line Listing" and "Infection Trend" reports were completed on 11/12/14 for all residents with reported infections.

Licensed nursing staff will be in-serviced on the facility policy and procedure on for "Trending and Tracking Infections" on 11/25/14 by the Director of Nursing. The Director of Nursing or her designee will monitor tracking and trending logs for compliance monthly and report the findings to the Quality Assurance/Improvement Committee monthly.

Any future noncompliance regarding Tracking and Trending will be reported to the Quality Assurance/Improvement Committee by the Director of Nursing for immediate action to resolve.

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F 441	<p>Continued From page 6</p> <p>transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, review of infection control logs and interview, it was determined the facility failed to establish and maintain an effective infection control program as evidenced by the facility did not properly track and trend infections for 3 of 3 (August, September and October 2014) months.</p> <p>The findings included:</p> <p>Review of the facility's "Policy & [and] Procedure For Trending and Tracking Infection" documented, "...collect and track information regarding infections related to residents on a monthly basis... Trending information will be collect and graphed..."</p> <p>During an interview in the Director of Nursing's (DON) office on 11/11/14 at 5:09 PM, the administrator was shown the infection log for the months of August, September and October 2014 and was asked if they were tracking and trending their infections. The Administrator stated, "No, this is all we do." The Administrator was asked if they should be tracking and trending. The Administrator stated, "Yes."</p> <p>During an interview in the nurse's station on 11/12/14 at 8:48 AM, the DON was asked about the facility not tracking and trending the residents' infections. The DON stated, "We will now."</p>	F 441		

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F 497 F 497 SS=E	Continued From page 7 483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Certified Nursing Assistant (CNA) in-service records, it was determined the facility failed to ensure CNAs received at least 12 hours of in-service training for 5 of 5 (CNA #1, 2, 3, 4 and 5) CNAs employed the entire year of 2013. The findings included: Review of the 2013 CNA in-service records documented the following: a. CNA #1 date of hire 7/18/12 had a total of 9 hours. b. CNA #2 date of hire 7/26/12 had a total of 11 hours. c. CNA #3 date of hire 7/29/10 had a total of 11 hours. d. CNA #4 date of hire 10/9/12 had a total of 11	F 497 F 497	F 497- All Certified Nursing Assistants will be provided with 12 hours of in-service training every calendar year from January to December. The Director of Nursing reviewed all in-service logs since January 2014 of all Certified Nursing Assistants who have been employed since that time. The Director of Nursing or her designee will maintain an in-service training log for each Certified Nursing Assistant. Hours will be tallied at the end of the calendar year for all Certified Nursing Assistants who have been employed for the previous 12 months. Any Certified Nursing Assistant who does not have the 12 hours required will be provided additional in-service training to meet the 12 hour regulation prior December 31 st . All nursing staff will be in-serviced regarding the 12 hour minimum training requirements on 11/25/14. The Director of Nursing will monitor for compliance monthly. Any future noncompliance with Certified Nursing Assistant in-service requirements will be reported to the Quality Assurance/Improvement Committee by the Director of Nursing for immediate action to resolve.	11-25-14

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F 497	Continued From page 8 hours. e. CNA #5 date of hire 10/24/12 had a total of 11 hours. During an interview in the conference room on 11/12/14 at 4:20 PM, the business office manager (BOM) was asked if these CNA in-service records accurately documented the total number of in-service training hours for 2013. The BOM stated, "Yes." During an interview in the conference room on 11/12/14 at 4:57 PM, the Director of Nursing (DON) was asked how many hours of in-service training is required for CNAs. The DON stated, "It's based on their performance reviews, but we typically do 10 to 12 hours per year."	F 497		
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and interview, it was determined the facility failed to ensure the physician was promptly notified of abnormal laboratory (lab) results for 1 of 7 (Resident #7) sampled residents reviewed of the 20 residents included in the stage 2 review. The findings included: Review of the facility's "Change in Condition" policy documented, "...Purpose: To ensure prompt notification of the resident, the attending	F 505	F 505- The facility will ensure each resident's laboratory results are reported to his/her physician promptly and any new physician orders will be placed in the resident record immediately. The facility will ensure that the physician is notified promptly of any change in condition, including abnormal laboratory findings, on all current residents.	11-25-14

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F 505	<p>Continued From page 9</p> <p>physician... of changes in the resident's physical, psychosocial and/or mental condition and/or status... Specific information that requires prompt notification include, but is not limited to: Abnormal lab values..."</p> <p>Medical record review for Resident #7 documented an admission date of 8/6/14 with diagnoses of Iron Deficiency Anemia, Senile Dementia, Hepatic Encephalopathy, Chronic Kidney Disease, Hypertension and mixed Hyperlipidemia. Review of a physician's order dated 8/22/14 documented, "Obtain BMP [Basic Metabolic Panel] & [and] BNP [Brain Natriuretic Peptide] to R/O [rule out] CHF [Congestive Heart Failure] exacerbation..."</p> <p>Review of a laboratory report dated 8/23/14 documented, "...BASIC METABOLIC... POTASSIUM - Result 5.6... H [high]... Reference 3.5 - [to] 5.3 MMOL/L [Millimoles per liter]... CARBON DIOXIDE - Result 19... L [low] Reference 22 - 30 MMOL/L... BUN [Blood Urea Nitrogen] Result 74... H... reference 9-20 MG/DL [milligrams/deciliter]... CREATININE... Result 3.78... H... Reference... 0.66-1.25 MG/DL..."</p> <p>Review of a physician's order dated 8/25/14 documented, "...Increase Lasix to 80 mg 1 PO [by mouth] Q [every] Day... repeat BMP wk [week] of 09-02-14..."</p> <p>During an interview in the conference room on 11/12/14 at 11:00 AM, Nurse #2 was asked about the laboratory (labs) results being called to the physician. Nurse #2 stated, "The labs were done on the 22nd and went out that afternoon. The results would come back on the 23rd if it was on a Saturday there's no one in the front office to get</p>	F 505	<p>All laboratory findings will be faxed to the medication room fax machine, rather than to the business office. The laboratory was notified by telephone and by letter regarding the facility's request for designated fax machine. Licensed staff will use a "Lab Log" to identify lab orders and notify the physician as results return from the lab. Licensed nursing staff will be in-serviced on the policy and procedure regarding "Change in Condition", "Lab Log" and prompt notification of the resident's physician regarding these changes on 11/25/14 by the Director of Nursing.</p> <p>Any future noncompliance with reporting resident change in condition promptly to the resident's physician will be reported to the Quality Assurance/Improvement Committee by the Director of Nursing for immediate action to resolve the issue.</p>	
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NAME OF PROVIDER OR SUPPLIER BENCHMARK HEALTHCARE OF PURYEAR INC		STREET ADDRESS, CITY, STATE, ZIP CODE 220 COLLEGE STREET PURYEAR, TN 38251		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 505	Continued From page 10 access to that copier, so there would be no access until Monday the 25th..." Nurse #2 verified the physician was not promptly notified of the abnormal lab results.	F 505		

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