### Summary Statement of Deficiencies

**F 166**

**SS=D**

483.10(h)(2) **RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES**

A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

This REQUIREMENT is not met as evidenced by:

- Based on record review and interview the facility failed to resolve a grievance for one resident of (#6) of six residents reviewed.

The findings included:

- Resident #6 was readmitted to the facility on April 5, 2009, with diagnoses including Dementia, and Hypertension.

- Medical record review of the Minimum Data Set dated January 14, 2010, revealed the resident had short term memory impairment and modified independence for daily decision making skills.

- Review of the resident counsel minutes from October 2009, through March 2010, revealed call light response time was reported as a problem in October, 2009, December 2009, and January 2010.

- Review of the February 2010 family counsel minutes revealed concerns regarding call light response time.

- Observation on April 19, 2010, from 9:00 a.m. to 10:15 a.m. revealed the call lights were answered timely.

- Interview with the resident counsel president on April 19, 2010, at 3:30 p.m., in the dining room revealed the call light response time has improved some.

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**This Plan of Correction is the facility's credible allegation of compliance.**

"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."

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**Right To Prompt Efforts To Resolve Grievances**

Residents concerns about call lights are being addressed on an individual basis.

Residents using call lights have the potential to be affected.
Residents and families are encouraged to use the facility's Concern and Comment Cards to advise the facility of call light issues. Call light audits and Concern and Comment Cards will be reported to the Performance Improvement Committee (Executive Director, Director of Nursing, Medical Director, Rehab Manager, Director of Social Services, Activity Director, Dietary Manager, Medical Records, and Pharmacy Consultant), for six months.

Develop/Implement Abuse/Neglect Policies

After investigation, if the origin of an injury is unknown, it will be reported to the State Agency.

Any future injury of unknown origin after a thorough investigation will be reported to the State Agency.
F 226 Continued From page 2
knowledge of any incident and the origin of the
bruise is unknown.
Interview with the Director of Nursing on April 19,
2010, at 1:30 p.m., in the conference room,
confirmed a bruise was noted on February 5,
2010, the origin of the bruise is unknown and the
injury of unknown origin was not reported to the
State Agency.

483.75(f)(1) RES
C/o TN00025376
483.75(f)(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 maintain complete medical
records for three residents (#1, #4, #3) of six
sampled residents.

The findings included:
Resident #1 was admitted to the facility on
September 28, 2009, with diagnoses including

Monday through Friday, by
the Events Interdisciplinary
Team. If the event is of
unknown cause it will be
reported to the State Agency.
Any reportable event will be
reported to the Performance
Improvement Committee
monthly. (Executive
Director, Director of Nursing,
Medical Director, Rehab
Manager, Director of Social
Services, Activity Director,
Dietary Manager, Medical
Records, and Pharmacy
Consultant), monthly.

Records-Complete
Accurate/Accessible

Beginning on April 13,
Nursing Administration
reviews MARs and TARs
daily, Monday through
Friday, for completeness.
Any omissions are noted and
corrected in a timely fashion.
All residents’ MARs and
TARs are reviewed daily.
Continued From page 3

Pancreatitis, Diabetes, and End Stage Renal Disease and was discharged from the facility to home on October 26, 2009.

Medical record review of the Physician’s order dated October 9, 2009, revealed "...Flush PICC (intravenous Catheter) line (with) 10 ml (milliliters) of saline per each lumen q (every) 12 (hours) (and) PRN (as needed) followed by 1 ml of heparin flush per each lumen. (change picc line (dressing) q (every) week and prn"

Medical record review of the Medication Administration Record for the month of October 2009, revealed no documentation the PICC line was flushed on October 10, 11, 17, 25, 2009. Continued review revealed the PICC line was documented as flushed one time on October 13, 24, 2009.

Medical record review of the treatment record for October 2009 revealed the only documented dressing change was October 24, 2009.

Interview with the Director of Nursing on April 19, 2010, at 1:00 p.m., in the conference room, confirmed the above findings and confirmed the medical record was incomplete.

Resident #4 was admitted to the facility on May 21, 2009, with diagnoses including Psychosis, Dementia, Hypertension, and Osteoporosis.

Medical record review of the Physician order dated March 15, 2010, revealed "...brush teeth twice a day ..."

Medical record review of the daily care flow report from March 15, 2010, through March 31, 2010, All residents MARs and TARs are reviewed daily and corrected timely. If the deficient practice continues, the nurse will be counseled. Results of these daily audits will be reported to the Performance Improvement Committee monthly (Executive Director, Director of Nursing, Medical Director, Rehab Manager, Director of Social Services, Activity Director, Dietary Manger, Medical Records, and Pharmacy Consultant).
**F 514** Continued From page 4


Observation on April 19, 2010, at 8:30 a.m., revealed the resident was being prepared for shower per staff. Observation on April 19, 2010, at 11:00 a.m., revealed the resident seated in geri-chair clean and well groomed.

Interview with the Director of Nursing on April 19, 2010, at 1:00 p.m., in the conference room, confirmed the above findings and confirmed the medical record was incomplete.

Resident #3 was admitted to the facility on February 5, 2010, with diagnoses including Dementia and Psychosis and discharge from the facility to an Assisted Living Facility on April 9, 2010.

Medical record review of the Physician order dated March 15, 2010 revealed "honey thick shake (with) hydration cart and hs snack. Medical record review of the Physician order dated March 23, 2010, revealed "mighty shake (honey thick) at hydration pass"

Medical record review of the hydration pass record revealed no documentation the resident received the honey thick milk shake with hydration pass after March 13, 2010.

Medical record review of the Dietary note dated March 30, 2010, revealed "wt 182, an overall increase 6 lbs x 1 wk (week)... dc (discontinue) mighty shakes at hs(hour sleep) snack..."
Telephone interview with the Director of Nursing on April 21, 2010, at 3:00 p.m., confirmed the above findings and confirmed the medical record was incomplete.

c/o TN00025370, TN00024811, TN00025371