**NAME OF PROVIDER OR SUPPLIER**

**COLONIAL HILLS NURSING CENTER**

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

2034 COCHRAN RD

MARYVILLE, TN 37803

<table>
<thead>
<tr>
<th>(X4) ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
<td></td>
</tr>
</tbody>
</table>

Investigation of complaint # TN-28971 was conducted at Colonial Hills Nursing Center on December 1-15, 2011. Based on this investigation, the facility was cited Immediate Jeopardy (a situation in which a provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment or death) for two non-related areas, Resident Abuse and Quality of Care/Therapeutic Diets.

The Regional Vice President, the Regional Director of Clinical Services and the Director of Nursing were informed of the Immediate Jeopardy in the Administrator's office on December 5, 2011, at 12:15 p.m.

The Immediate Jeopardy related to Resident Abuse for sexual assault of two residents (#1, #2), was effective November 26, 2011 and is ongoing.

The Immediate Jeopardy related to quality of care for inappropriately made therapeutic diets for seven residents (#6, #7, #8, #9, #10, #11, #12,), was effective November 23, 2011 with the immediacy of the Jeopardy removed on December 6, 2011 after verification of compliance. The deficiencies will be lowered in scope and severity from a "K" level to an "E" level.

Substandard Quality of Care was cited under tags F-223, F-225, and F-309 all at scope and severity levels of a "K".

A Partial Extended Survey was conducted on
F 000 Continued From page 1
December 15, 2011.

F 157 483.10(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:
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID 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>
</tr>
</thead>
<tbody>
<tr>
<td>F 157</td>
<td>Continued From page 2 Based on medical record review, review of the investigation report, facility policy review and interview, the facility failed to notify the physician and the families related to an incident of sexual assault for two (#1 and #2) of four residents at risk of sexual assault. The facility's failure placed two residents (#1 and #2) in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident). The Regional Vice President, the Regional Director of Clinical Services and the Director of Nursing were informed of the Immediate Jeopardy in the Administrator's office on December 5, 2011, at 12:15 p.m. The Immediate Jeopardy was effective November 26, 2011, and is ongoing. A partial extended survey was conducted on December 15, 2011. The findings included: Resident #1 was admitted to the facility on April 20, 2010, with diagnoses including Fractured Right Arm, Dementia, Hypertension, Diabetes, Osteoarthritis, History of Breast Cancer, Degenerative Joint Disease and Parkinson's Disease. Medical record review of the Minimum Data Set (MDS) dated November 22, 2011, revealed the resident scored fourteen of fifteen on the Brief Interview for Mental Status (BIMS) with intact cognitive skills and no memory impairment.</td>
<td>F 157</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID PREFIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>ID PREFIX TAG</td>
<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td>COMPLETION DATE</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>---------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>F 157</td>
<td>Continued From page 3</td>
<td>F 157</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Review of a written statement by Certified Nursing Assistant (CNA) #1 dated November 26, 2011, revealed, "I was walking by the café (an open, unenclosed, offset in the hallway between the A wing and the Transitional Care Unit) and saw (resident #5's) son feeling on (resident #1's) leg. I asked (resident #1) to come with me...Told 2 nurses and (Assistant Director of Nursing-ADON)...."

Review of an interview with resident #1 by the Registered Nurse (RN #1)/weekend Supervisor dated November 26, 2011, at 6:25 p.m., revealed, "The gentleman began rubbing my leg in places he should not have been...it made me uncomfortable. I kept moving his hand from my leg...he should have known I did not like it...."

Review of a second written statement by CNA #1 dated November 29, 2011, at 12:00 p.m., revealed, "...On Saturday 11-26-11 (November 26, 2011)...I walked by the café area and (residents #1, #2, #3 and #4) were playing cards...I went and notified (Licensed Practical Nurses #1 and #2) that (resident #5's son) was here. I did this because in the past few weeks he had been different-stumbly. I began to walk back to the TCC (Transitional Care Unit) and as I passed the café noticed that (resident #5's son) was leaning over the table and I could not see his arms. I went over and saw his hand moving toward the crease of (resident #1's) leg...toward the pelvic region...I removed (resident #1) immediately...I said did anything funny happen at the table? She said "You mean the man touching me? I took her to her room and notified (LPN #2) and (ADON)...I told (ADON) he is still down in the..."
<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>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
</table>
| F 157             | Continued From page 4 café with other residents..." Review of the Social Worker interview with resident #1 dated November 28, 2011, at 12:45 p.m., revealed, ",...spoke with resident regarding an incident that occurred on Saturday, (November 26, 2011). Resident was in the café area playing cards when a man came up to them. She reports that the man...put his hand on her leg and started rubbing her leg. Then he moved his hand between her legs and started rubbing her vaginal area. Resident reports that a CNA (#1) walked by and saw him doing this and removed the resident from the area. Resident reported the incident to the CNA (#1) who witnessed the event...
Medical record review of a physician's progress note dated November 28, 2011, (no time documented) by the Nurse Practitioner (NP) revealed, "...A man that she did not know but knew his mother was a resident...sat down @ (at) table...started talking to her...started putting his hand on her thigh (and) vaginal area...A CNA saw what happened and removed her from the situation...told CNA...several people talked to (resident #1). She was very frightened...pushed him away but did not yell or scream...didn't sleep all night...participates in conversation...able to give clear detail...Periarea (with) erythema-mild that she says is not unusual...happens due to...chronic incontinence...does not have bruises or evidence of physical harm. Vaginal exam not performed..."
Review of the facility's investigation dated November 28, 2011, and medical record review of nurses' notes dated November 28 and 29, | F 157 | | |
<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>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 157</td>
<td>Continued From page 5 2011, (no nurse's note documented on November 26, 2011) revealed no documentation the physician and the family was notified of the sexual assault. Interview on December 5, 2011, at 7:30 a.m., in the office (previously identified by the Administrator as the corporate office) with the spouse of resident #1 confirmed the facility did not notify him of the sexual assault on his wife on Saturday, November 26, 2011. Continued interview with the spouse revealed resident #1 informed him of the sexual assault on Sunday morning, November 27, 2011, when he came to visit the resident. Interview on December 5, 2011, at 10:30 a.m., in the office, with the Regional Vice President (RVP), the Regional Director of Clinical Services (RDCS) and the Director of Nursing (DON) confirmed resident #1 was sexually assaulted on Saturday, November 26, 2011, &quot;around&quot; 6:00 p.m., and confirmed the facility failed to notify the physician and the family of the assault. Resident #2 was admitted to the facility on November 21, 2008, with diagnoses including Peripheral Vascular Disease, Ischemic Heart Disease, Osteoporosis, Hypertension, Chronic Obstructive Pulmonary Disease, Gastrointestinal Reflux Disease, Diabetes and Bilateral, above the Knee Amputation. Medical record review of the Minimum Data Set (MDS) dated November 1, 2011, revealed the resident scored 15 of 15 on the Brief Interview for Mental Status (BIMS); had intact cognitive skills and no memory impairment; had no behavioral</td>
<td>F 157</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID PREFIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>ID PREFIX TAG</td>
<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td>COMPLETION DATE</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>---------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>F 157</td>
<td>Continued From page 6 symptoms; and required extensive assistance with most activities of daily living (ADLs); and used an electric wheelchair for mobility.</td>
<td>F 157</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review of an interview dated November 26, 2011, at 6:50 p.m., with resident #2 by RN #1 revealed resident #2 reported, &quot;While I was in the coffee area (café) there was a man with a beard who tried to put his hand under my shirt and tried to rub my leg. I told him to quit and then he tried to push his chair closer to mine. I told him it was time for me to smoke so he followed me out to the smoking area and asked me for a cigarette which I gave him. I sure would not want to be alone with him. His mother is (resident #5).&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review of an interview with resident #2 by the Director of Social Services (DSS) dated November 28, 2011, at 12:30 p.m., revealed the resident reported being in the café area playing cards with &quot;several&quot; other residents when a man approached the table. The resident reported the man rubbed another resident (#1) on the leg and in between the legs. The man put his hand up the shirt of resident #2. Resident #2 went to the smoking area, followed by the man. The man asked for a cigarette from resident #2 and the resident complied. The resident reported she &quot;went back inside a different way&quot; because she was afraid he was going to follow her back to her room. The resident reported she was &quot;so scared&quot; that she hid in the corner of her room for approximately fifteen minutes.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical record review of a Nurse Practitioner note dated November 28, 2011, (no time documented) revealed, &quot;Seen for exam due to incident 11/26/11 (November 26, 2011). She was</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

COLONIAL HILLS NURSING CENTER

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

2034 COCHRAN RD

MARYVILLE, TN 37803

**DATE SURVEY COMPLETED**

12/15/2011

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**445181**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**Multiple Construction**

**A. BUILDING**

**B. WING**

**DATE SURVEY COMPLETED**

04/24/2012

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

CENTERS FOR MEDICARE & MEDICAID SERVICES

**OMB NO. 0938-0391**

**PRINTED:** 04/24/2012

**FORM APPROVED:**

W5HQ11

**Previous Versions Obsolete**

**Event ID:** WSHQ11

**Facility ID:** TN0502

If continuation sheet Page 7 of 80
Continued From page 7
playing cards (with) other residents in the café (3 other women) @ (at) the table. She says another resident's son came over to the table & (and) said he wanted to learn to play cards. He leaned over & was rubbing the other resident's leg up her thigh. The CNA witnessed this & took that resident (#1) away. (Resident #2) says he then went to her & started lifted her shirt in the back & tried to put his hand up her shirt. She knocked him away. Then he tried to put his hand on her leg & knocked him away. She said she moved away. He followed her to smoking area...she said she watched him & as soon as she finished smoking she hid in her room. She felt scared but did not yell...(No) bruises or marks noted...Discussed (with) her as far as emotional turmoil. She declines any psych (psychiatric) consult @ this time..."

Review of an interview with resident #2's son by the Director of Social Services (DSS) dated November 28, 2011, at 11:45 a.m., revealed "(Resident #2's son) spoke with his mother...who reported to him that...she was at the café playing cards when a resident's son came over to the table and started inappropriately touching the resident and some of the other residents... (Resident #2's son) confronted the man today when he was seen in the building and told him in no uncertain terms that he better not hear of him being anywhere near his mother again."

Review of the facility's investigation dated November 28, 2011, and medical record review of a nurse's note dated November 28, 2011, (no nurses' note documented for November 26 and 27, 2011) revealed no documentation the physician and the family was notified on
<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>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 157</td>
<td>Continued From page 8 November 26, 2011, of the sexual assault.</td>
<td>F 157</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review of the facility's policy for &quot;Abuse and/or Neglect Investigation&quot; revealed, &quot;...When an incident or suspected incident of resident abuse and/or neglect is reported, the Administrator will appoint a representative to investigate the occurrence...The representative will...assure that the physician and responsible parties have been notified of the circumstance...&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Interview on December 5, 2011, at 1:30 p.m., in the office, with the Director of Social Services (DSS) confirmed the facility failed to notify the family of resident #2 of the sexual assault which occurred on Saturday, November 26, 2011, and confirmed the resident informed the family on Monday, November 28, 2011.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Interview on December 8, 2011, at 11:20 a.m., in the dining room (enclosed room on one end of the dining room) with the Nurse Practitioner (NP) confirmed the NP and the physician were not notified until Monday, November 28, 2011, of the sexual assaults which occurred to residents #1 and #2 on November 26, 2011. The NP stated, &quot;If we had been notified, I would have come to the facility even though I wasn't on call and performed physical exams...&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C/O #28971</td>
<td>483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/IN VOLUNTARY SECLUSION</td>
<td>F 223</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SS=K</td>
<td>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, review of the facility investigation, observation, review of facility policy, review of the weekend communication notebook and interview, the facility failed to protect two residents (#1 and #2) from sexual assault of four female residents reviewed who were placed at risk for sexual assault. The facility failed to immediately remove the male alleged perpetrator from the facility after resident #1 was sexually assaulted, allowing the male alleged perpetrator to sexually assault resident #2 and placing all four female residents at risk for sexual assault.

The facility's failure placed all female residents in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident).

The Regional Vice President, the Regional Director of Clinical Services and the Director of Nursing were informed of the Immediate Jeopardy in the Administrator's office on December 5, 2011, at 12:15 p.m.

The Immediate Jeopardy was effective November 26, 2011, and is ongoing. A partial extended survey was conducted on December 15, 2011.
### Statement of Deficiencies and Plan of Correction

**A. BUILDING**

**PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**

<table>
<thead>
<tr>
<th>A. BUILDING</th>
<th>B. WING</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**STATE OF TN**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**FORM APPROVED OMB NO. 0938-0391**

**PRINTED: 04/24/2012**

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

**2034 COCHRAN RD**

**MARYVILLE, TN 37803**

**NAME OF PROVIDER OR SUPPLIER**

**COLONIAL HILLS NURSING CENTER**

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID 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>
</tr>
</thead>
<tbody>
<tr>
<td>F 223</td>
<td>Continued From page 10 The findings included: Resident #1 was admitted to the facility on April 20, 2010, with diagnoses including Fractured Right Arm, Dementia, Hypertension, Diabetes, Osteoarthritis, History of Breast Cancer, Degenerative Joint Disease and Parkinson's Disease. Medical record review of the Minimum Data Set (MDS) dated November 22, 2011, revealed the resident scored fourteen of fifteen on the Brief Interview for Mental Status (BIMS) with intact cognitive skills and no memory impairment; had no behavior symptoms; required limited to extensive assistance with activities of daily living (ADL); and used a manual wheelchair for mobility. Review of a written statement by Certified Nursing Assistant (CNA) #1 dated November 26, 2011, revealed, &quot;I was walking by the café (an open, unenclosed, offset in the hallway between the A wing and the Transitional Care Unit) and saw (resident #5's) son feeling on (resident #1's) leg. I asked (resident #1) to come with me...Told 2 nurses and (Assistant Director of Nursing-ADON)...&quot; Review of an interview with resident #1 by Registered Nurse (RN #1)/Weekend Supervisor dated November 26, 2011, at 6:25 p.m., revealed, &quot;The gentleman began rubbing my leg in places he should not have been...It made me uncomfortable. I kept moving his hand from my leg...he should have known I did not like it. I did not say anything to him because I did not want to upset the ladies who were sitting with me. I don't</td>
<td>F 223</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DATE SURVEY COMPLETED**

C

**DATE**

12/15/2011
**NAME OF PROVIDER OR SUPPLIER**

COLONIAL HILLS NURSING CENTER

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID 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>
</tr>
</thead>
<tbody>
<tr>
<td>F 223</td>
<td>Continued From page 11 want to cause him any trouble. I really like his mother (resident #5)...&quot;</td>
<td>F 223</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Review of a second written statement by CNA #1 dated November 29, 2011, at 12:00 p.m., revealed, "...On Saturday 11-26-11 (November 26, 2011)...I walked by the café area and (residents #1, #2, #3 and #4) were playing cards...I went and notified (Licensed Practical Nurses (LPN) #1 and #2) that (resident #5's son) was here. I did this because in the past few weeks he had been different-stumbly. I began to walk back to the TCC (Transitional Care Unit) and as I passed the café noticed that (resident #5's son) was leaning over the table and I could not see his arms. I went over and saw his hand moving toward the crease of (resident #1's) leg...toward the pelvic region...I removed (resident #1) immediately...I said did anything funny happen at the table? She said "You mean the man touching me? I took her to her room and notified (LPN #7) and (ADON)...I told (ADON) he is still down in the café with other residents..."

Review of a written statement by RN #1 dated November 29, 2011, at 11:40 (unclear whether a.m. or p.m.) revealed RN #1 and the ADON spoke to the male alleged perpetrator in the smoking area (located outside the facility on C wing) and informed him he was not allowed to touch residents. RN #1 re-entered the building from the smoking area and learned resident #2 (left at the table in the café when resident #1 was removed from the area) had also been sexually assaulted after resident #1 was removed from the café.

Review of a written statement by the ADON
### SUMMARY STATEMENT OF DEFICIENCIES

**(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)**

<table>
<thead>
<tr>
<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>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 223</td>
<td>Continued From page 12</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(undated), revealed, &quot;Time of incident: (6:15 p.m.)...Date of incident: (11-26-11) (November 26, 2011)...At approx (approximately) 6pm (6:00 p.m.), CNA (#1), reported to me that (CNA #1) observed a visitor (resident #5's) son touching a resident's leg in the coffee café area...told me that (CNA #1) immediately removed the resident (#1) and escorted...to...room. I asked where the man went, and (CNA #1) told me that he had gone outside to smoke, and staff was outside monitoring him and resident smokers. Knowing that he was under supervision, I contacted (Administrator)...immediately. (Administrator) instructed me to talk with the man about keeping his hands to himself, and that he was not to go in any (residents') room besides his mothers. I asked (Administrator) if I should complete incident reports or ask the man to leave and (Administrator) said no... (RN #1) went with me to address the man, outside in smoking area. I noticed man was sharing a cigarette with (resident #2). She did not seem distressed. We waited until all residents had gone inside. We told the man that it was not ok to touch any resident, even if it was a friendly gesture. We told him to stay out of any resident's room besides his moms. He stated he didn't know what we were talking about, but he understood. I could smell the alcohol on his breath. I returned inside the building. (RN #1) went to interview the residents (#1 and #2) and obtain their statements. I then went home.&quot;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Review of the Social Worker interview with resident #1 dated November 28, 2011, at 12:45 p.m., revealed, "...spoke with resident regarding an incident that occurred on Saturday, November 26, 2011). Resident was in the café area playing..."
<table>
<thead>
<tr>
<th>F 223 Continued From page 13</th>
<th>F 223</th>
</tr>
</thead>
<tbody>
<tr>
<td>cards when a man came up to them. She reports that the man...put his hand on her leg and started rubbing her leg. Then he moved his hand between her legs and started rubbing her vaginal area. Resident reports that a CNA (#1) walked by and saw him doing this and removed the resident from the area. Resident reported the incident to the CNA (#1) who witnessed the event...&quot;</td>
<td></td>
</tr>
</tbody>
</table>

Medical record review of a physician's progress note dated November 28, 2011, (no time documented) by the Nurse Practitioner (NP) revealed, "...A man that she did not know but knew his mother was a resident...sat down @ (at) table...started talking to her...started putting his hand on her thigh (and) vaginal area...A CNA saw what happened and removed her from the situation...told CNA...several people talked to (resident #1). She was very frightened...pushed him away but did not yell or scream...didn't sleep all night...participates in conversation...able to give clear detail...Periare a (with) erythema-mild that she says is not unusual...happens due to...chronic incontinence...does not have bruises or evidence of physical harm. Vaginal exam not performed..." 

Observation and interview on December 5, 2011, at 8:10 a.m., in the resident's room revealed the resident was sitting in a chair at the bedside; was alert and oriented; and the spouse was in the room. Interview with the resident on December 5, 2011, at 8:10 a.m., revealed, "The girls were fixing to play Rook. This guy came in and sat down by me...started digging." Observation revealed the resident pointed to the vaginal area and using both hands started "digging" at the...
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Colonial Hills Nursing Center

**Address:**
- 2034 Cochran Rd
- Maryville, TN 37803

**Provider's Plan of Correction**
- **(Each Corrective Action Should Be Cross-referenced to the Appropriate Deficiency)**

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>Completion Date</th>
</tr>
</thead>
</table>
| F 223 | Continued From page 14 | Vaginal area. Continued interview with the resident revealed, "...(CNA #1) came to the table, got my hand and said come go with me...They took me to my room. I saw him the day after and he spoke to me...acted like nothing had happened...He had always been so nice to all us girls. I just tried to figure out why it happened...It sure did tear me up. I was nervous as a cat after it was over with. I would have been scared to death if (CNA #1) hadn't been there."
| F 223 | Continued From page 14 | Interview on December 1, 2011, at 10:05 a.m., in the office (previously identified by the Administrator as the corporate office) with CNA #1 confirmed CNA #1 observed a male visitor with his hand "going from the outer thigh toward the inner thigh" of resident #1. The resident pushed the man's hand away, but he tried to put his hand back on the resident. Continued interview with CNA #1 revealed the resident "stayed in her room all day Sunday, and the family was in the room almost all day." Continued interview with the CNA confirmed the CNA immediately informed the ADON of the incident and informed the ADON the man was "still at the table with other residents." The CNA informed the ADON "about past employees' concerns with him stumbling and like impaired." The ADON instructed the CNA to "write a statement; go back to work; and not talk about it." Continued interview with CNA #1 confirmed the CNA informed LPN #1 the man was in the café area with female residents and of the CNA's concern regarding recent behavior of the man when he was visiting the facility. CNA #1 confirmed after the incident was observed by CNA #1, LPN #1 and LPN #2 were immediately informed. |
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** COLONIAL HILLS NURSING CENTER  
**Street Address, City, State, Zip Code:** 2034 COCHRAN RD, MARYVILLE, TN 37803  
**Provider's Plan of Correction**

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>ID 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>
</tr>
</thead>
</table>
| F 223         | Continued From page 15  
Interview on December 1, 2011, at 10:45 p.m., with LPN #1 confirmed CNA #1 informed the LPN on Saturday, November 26, 2011, that (resident #5's son) was sitting at the card table with other residents and stated, "He's done strange things before." Continued interview with LPN #1 revealed LPN #1 told CNA #1 when (LPN #1) finished passing medications to a resident, (LPN #1) "would go check on it." Before the LPN finished giving the medications, the CNA "came up the hallway pushing (resident #1)" and stated, "I just saw him touching her leg." Continued interview with LPN #1 confirmed the ADON and the RN #1 were immediately informed of the sexual assault.  
 Telephone interview on December 13, 2011, at 12:10 p.m., with LPN #2 (on duty 3:00 p.m.-11:00 p.m. on November 26, 2011, at the time of the sexual assaults) confirmed on Saturday, November 26, 2011, CNA #1 "came up the hall with (resident #1)" and informed LPN #2 that a man had his hand on the resident's leg. I told her to take the patient to (resident's) room." Continued interview with LPN #2 confirmed LPN #2 had knowledge the male alleged perpetrator was still in the café area with other female residents because "]CNA #1) told me they were playing cards." Continued interview with LPN #2 confirmed LPN #2 did not remove the male alleged perpetrator from the other female residents.  
Resident #2 was admitted to the facility on November 21, 2008, with diagnoses including Peripheral Vascular Disease, Ischemic Heart Disease, Osteoporosis, Hypertension, Chronic Obstructive Pulmonary Disease, Gastrointestinal | F 223 | | | |
## Statement of Deficiencies and Plan of Correction

**Event ID:** WSHQ11  
**Provider/Supplier/CLIA Identification Number:** 445181  
**Date Survey Completed:** C  
**Date:** 12/15/2011

### Name of Provider or Supplier

**Colonial Hills Nursing Center**

### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>(X4) ID Prefix Tag</th>
<th>(X4) ID Prefix Tag</th>
<th>(X5) Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 223</td>
<td>F 223</td>
<td></td>
</tr>
</tbody>
</table>

**Continued From page 16**

Reflux Disease, Diabetes and Bilateral, above the Knee Amputation.

Medical record review of the Minimum Data Set (MDS) dated November 1, 2011, revealed the resident scored 15 of 15 on the Brief Interview for Mental Status (BIMS); had intact cognitive skills and no memory impairment; had no behavioral symptoms; and required extensive assistance with most activities of daily living (ADLs); and used an electric wheelchair for mobility.

Review of an interview dated November 26, 2011, at 6:50 p.m., with resident #2 by RN #1 revealed resident #2 reported, "While I was in the coffee area (café) there was a man with a beard who tried to put his hand under my shirt and tried to rub my leg. I told him to quit and then he tried to push his chair closer to mine. I told him it was time for me to smoke so he followed me out to the smoking area and asked me for a cigarette which I gave him. I sure would not want to be alone with him. His mother is (resident #5)."

Review of an interview with resident #2 by the Director of Social Services (DSS) dated November 28, 2011, at 12:30 p.m., revealed the resident reported being in the café area playing cards with "several" other residents when a man approached the table. The resident reported the man rubbed another resident (#1) on the leg and in between the legs. The man put his hand up the shirt of resident #2. Resident #2 went to the smoking area, followed by the man. The man asked for a cigarette from resident #2 and the resident complied. The resident reported she "went back inside a different way" because she was afraid he was going to follow her back to her...
F 223 Continued From page 17

The resident reported she was "so scared" that she hid in the corner of her room for approximately fifteen minutes.

Medical record review of a Nurse Practitioner note dated November 28, 2011, (no time documented) revealed, "Seen for exam due to incident 11/26/11 (November 26, 2011). She was playing cards (with) other residents in the café (3 other women) @ (at) the table. She says another resident's son came over to the table & said he wanted to learn to play cards. He leaned over & was rubbing the other resident's leg up her thigh. The CNA witnessed this & took that resident (#1) away. (Resident #2) says he then went to her & started lifted her shirt in the back & tried to put his hand up her shirt. She knocked him away. Then he tried to put his hand on her leg & knocked him away. She said she moved away. He followed her to smoking area...she said she watched him & as soon as she finished smoking she hid in her room. She felt scared but did not yell...(No) bruises or marks noted...Discussed (with) her as far as emotional turmoil. She declines any psych (psychiatric) consult @ this time..."

Observation and interview on December 1, 2011, at 3:00 p.m. in the resident's room revealed resident #2 was lying in bed and was alert and oriented. Interview revealed the man "tried to put his hand up my shirt...got his hand on my skin on my back...rubbed the top of my leg...felt scared...tried to get away from him. He kept trying to raise the arm of my (electric wheelchair). It was back in the café...playing Rook with (residents #1, #3 and #4). This man's mother was there. He touched (resident #1) first...rubbing her legs & trying to get in between
Continued From page 18 her legs...CNA walked by and saw it and pulled her (resident #1) out." Continued interview confirmed resident #2 was assaulted by the man after resident #1 was removed from the area. Continued interview revealed, "I moved away from him and told others I was going out to smoke. He followed me all the way to the smoking area. He asked me for a cigarette. I gave him one...I left and came down C wing and came back and hid in the corner of my room. I was still scared...afraid he was behind me...happened Saturday night after dinner...about 6:30 p.m...He (male alleged perpetrator) came in my room (Monday, November 28, 2011) before lunch and told me he didn't know what he was doing Saturday night. (Administrator) came in my room and took him out."

Review of a written statement dated November 30, 2011, by CNA #11 revealed on November 6, 2011, CNA #11 reported to RN #1 that a man identified as the son of resident #5 was in the smoking area making inappropriate sexual comments to the CNA and had touched the CNA's leg on two occasions. Continued review of the written statement by CNA #11 revealed on November 12, 2011, the son of resident #5 was pushing his mother in the wheelchair in the hallway on C wing (Resident resided on A wing.), and CNA #11 observed the man take his hand off the wheelchair and brush his hand along the "backside" of CNA #12 who had her back to the man. CNA #12 "thought it was the woman in the wheelchair" who touched her. CNA #11 told CNA #12, "That's the same man that was saying that stuff and touching my leg 2 weeks ago." CNA #12 reported the incident to RN #1.
Review of the facility's policy for "Protection of Residents: Reducing the Threat of Abuse & Neglect" revealed, "Charges of abuse and/or neglect are among the most serious allegations that can occur in a nursing home. Frail elderly and disabled residents are frequently powerless to protect themselves from physical or sexual assault and may be unable to communicate to family or staff that they have suffered from abuse. It becomes paramount for nursing home providers to champion the safety and protection of each resident. To minimize the threat of abuse and/or neglect, nursing homes must incorporate clear cut policies and practices that demonstrate a hard-line, zero tolerance approach to resident abuse...all residents have the right to be free from willful physical and/or emotional injury...Residents must not be subjected to abuse by anyone. This includes but is not limited to: staff, other residents, consultants, volunteers, staff from other agencies serving our residents, family members, the responsible party, friends, or any other individuals..."

Telephone interview on December 7, 2011, at 9:05 a.m., with RN #1 confirmed CNAs #11 and #12 informed RN #1 in November 2011, of the two incidents when resident #5's son inappropriately touched them and made sexually suggestive comments to CNA #11. Continued interview with RN #1 revealed she noted the incident with CNA #11 in a "spiral notebook" (weekend communication notebook) for the ADON to review on Monday morning, November 7, 2011. Continued interview with RN #1 confirmed RN #1 could not recall if an entry had been made in the notebook related to the complaint by CNA #12 on November 12, 2011.
### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 223</td>
<td>Continued From page 20</td>
<td></td>
<td>Review of the &quot;spiral notebook&quot; and interview on December 7, 2011, at 9:50 a.m., with the Director of Nursing (DON) confirmed the incident with CNA #11 was recorded on November 6, 2011, and confirmed no entry related to the sexually inappropriate behavior of the male alleged perpetrator on November 12, 2011, toward CNA #12. Continued interview with the DON revealed the ADON was responsible to review weekend entries on Monday following the weekend to determine if anything had happened over the weekend that needed to be addressed. Continued interview with the DON confirmed the DON had not been made aware and had no knowledge (prior to December 7, 2011) of the sexually inappropriate behavior of resident #5's son toward staff on November 6 or 12, 2011.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 223</td>
<td></td>
<td></td>
<td>Interview in the office on December 5, 2011, at 10:30 a.m., with the Regional Vice President (RVP), the Regional Director of Clinical Services (RDCS) and the Director of Nursing (DON) confirmed resident #1 and resident #2 were sexually assaulted on Saturday, November 26, 2011, &quot;around&quot; 6:00 p.m. Continued interview with the RVP, the RDCS and the DON confirmed after resident #1 was removed from the café area after being sexually assaulted, the other three female residents were left at the table with the male alleged perpetrator. Continued interview with the RVP, the RDCS and the DON confirmed resident #2 was sexually assaulted after resident #1 was sexually assaulted and was removed from the area.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Telephone interview on December 5, 2011, at 5:00 p.m., with the former Administrator</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Event ID:
Event ID: WSHQ11
Facility ID: TN0502

If continuation sheet Page 21 of 80
Continued From page 21
(Administrator at the time of the sexual assaults) confirmed the Administrator was notified on Saturday, November 26, 2011, at 6:20 p.m., by the ADON that resident #5's son had touched the arm and leg of two residents. Continued interview with the former Administrator confirmed the ADON informed the Administrator the male alleged perpetrator was "intoxicated" and making residents' nervous. Continued interview with the former Administrator confirmed the Administrator did not direct the ADON to escort the male alleged perpetrator from the facility.

Telephone interview on December 5, 2011, at 5:20 p.m., with the ADON confirmed CNA #1 informed the ADON on Saturday, November 26, 2011, at 6:00 p.m., that resident #5's son had touched the leg of resident #1; the resident was uncomfortable; and CNA #1 had removed the resident from the café area. Continued interview with the ADON confirmed resident #2 was sexually assaulted after resident #1 was removed from the area and confirmed the alleged male perpetrator was left in the café area with three other residents after he assaulted resident #1. The ADON confirmed, "There was a lag time when transported (resident #1) and when (resident #2) was assaulted."

Telephone interview on December 5, 2011, at 5:50 p.m., with RN #1 confirmed resident #1 and #2 were sexually assaulted by the son of resident #5 on Saturday, November 26, 2011. Continued interview with RN #1 confirmed RN #1 interviewed both residents about the assault on Saturday, November 26, 2011, and confirmed the written statement by RN #1 November 29, 2011, that both residents were sexually assaulted.
### Statement of Deficiencies and Plan of Correction

**Colonial Hills Nursing Center**  
2034 Cochran RD  
Maryville, TN 37803

#### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 223</td>
<td>Continued From page 22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 225</td>
<td>CO #28971</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SS=K</td>
<td>483.13(c)(1)(ii)-(iii), (c)(2) - (4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 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.

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).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

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...
**NAME OF PROVIDER OR SUPPLIER**

COLONIAL HILLS NURSING CENTER

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

2034 COCHRAN RD

MARYVILLE, TN  37803

---

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**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-REFERENCE TO THE APPROPRIATE DEFICIENCY)

**(X5) COMPLETION DATE**

F 225 Continued From page 23

appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, review of the facility investigation, facility policy review, observation and interview, the facility failed to immediately report allegations of sexual abuse to Law Enforcement and the State agency within the required time frame and failed to thoroughly investigate the sexual assault of two residents (#1 and #2) and the likelihood of sexual assault of two other residents (#3 and #4) who were left unattended while the alleged sexual perpetrator remained in the building. The facility failed to immediately assess residents #1, #2, #3 and #4 and other female residents in the facility to determine any physical signs of sexual assault. The facility failed to immediately interview residents #3 and #4 and other female residents in the facility to determine if the alleged male perpetrator had attempted or committed sexual assault on other female residents. The facility failed to immediately prevent further abuse of one resident (#2) after resident #1 was sexually assaulted. The facility failed to immediately remove the alleged perpetrator from the facility and prevent the alleged perpetrator from returning to the facility on two occasions after the sexual assaults occurred. The facility failed to implement their abuse polices and inform staff of the sexual assault by the identified alleged male perpetrator which placed all female residents at risk for sexual abuse.

The facility's failure placed all female residents in
NAME OF PROVIDER OR SUPPLIER

COLONIAL HILLS NURSING CENTER

<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>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
</table>
| F 225             | Continued From page 24 Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident). The Regional Vice President, the Regional Director of Clinical Services and the Director of Nursing were informed of the Immediate Jeopardy in the Administrator's office on December 5, 2011, at 12:15 p.m. The Immediate Jeopardy was effective November 26, 2011, and is ongoing. A partial extended survey was conducted on December 15, 2011. The findings included: Two residents (#1 and #2) were sexually assaulted on Saturday, November 26, 2011, between 6:00 p.m., and 6:30 p.m. The alleged male perpetrator was the son of resident #5. Review of the facility's policy for "Reporting suspected Crimes under the Elder Justice Act Policy revealed, "The purpose of this policy is to outline the procedures for how (facility) will ensure compliance with the reporting and other requirements of the Elder Justice Act...If there is a Reasonable Suspicion that a crime had occurred at the Facility's location that involves any resident or other individual receiving care...it must be reported to local Law Enforcement and State Survey Agency as follows:...No Serious Bodily Injury-As soon as practical, but not later than 24 hours. If the resident or person receiving care at a Facility does not incur a Serious Bodily Injury resulting from the suspected crime, the
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>445181</td>
<td>A. BUILDING</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>B. WING</td>
<td>12/15/2011</td>
</tr>
</tbody>
</table>

NAME OF PROVIDER OR SUPPLIER

COLONIAL HILLS NURSING CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

2034 COCHRAN RD
MARYVILLE, TN 37803

<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>
<th>(X5) COMPLETION DATE</th>
<th>ID PREFIX 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 225</td>
<td>Continued From page 25 suspicion shall be reported not later than 24 hours after forming the suspicion...&quot;</td>
<td>F 225</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Review of the facility's policy for "Reporting Alleged Abuse" revealed, "This facility does not condone resident abuse and/or neglect by anyone. This includes but is not limited to: staff members, other residents, consultants, volunteers, staff from other agencies serving our residents, family members, the responsible party, sponsors, friends, or other individuals. All personnel will promptly report any incident or suspected incident of resident abuse and/or neglect, including injuries of unknown origin...the incident will be reported immediately to the administrator or his designated representative and the director of nursing...The supervisor notifies the director of nursing and the executive director of the alleged incident...Federal requirements mandate that facilities must ensure all allegations of abuse are reported immediately to their state survey agency...The immediate reports should be submitted as soon as possible, but no later than 24 hours of a facility learning of an allegation...

Review of the facility's policy for "Abuse and/or Neglect Investigation" revealed, "...All reports of abuse will be promptly and thoroughly investigated...When an incident or suspected incident of resident abuse and/or neglect is reported, the Administrator will appoint a representative to investigate the occurrence....The representative will utilize the Incident Investigation Questionnaire to complete the investigation...The representative will review the Incident Report for completeness...The investigation shall include a written summary of:
Review of the facility’s investigation of the sexual assaults on resident #1 and #2 revealed no documentation residents #1 and #2 were immediately assessed for signs of harm from the sexual assault. Residents #3 and #4 (who were in the café area with resident #1 and #2) and no other female residents were immediately assessed or interviewed to ensure no other female resident had been sexually assaulted by the alleged male perpetrator. Review of the facility's investigation revealed the investigation of the sexual assaults was not initiated until Monday, November 28, 2011 (two days after the assaults occurred).

Interview in the office on December 1, 2011, at 12:35 p.m., with LPN #3 (on duty 7:00 a.m. to 3:00 p.m. shift on, Monday, November 28, 2011, on A wing where resident #1 resided) confirmed LPN #3 observed the alleged perpetrator in the facility on Monday, November 28, 2011. Continued interview with LPN #3 confirmed LPN #3 had not been informed of the incident which occurred on Saturday, November 26, 2011, and the LPN stated, “I absolutely should have been
### Statement of Deficiencies and Plan of Correction

**Event ID:** WSHQ11  
**Facility ID:** TN0502

<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>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
</table>
| F 225            | Continued From page 27  
(informed)."  
Interview on December 1, 2011, at 12:45 p.m., in the office, with LPN #4/Unit Manager (A wing) revealed on Monday, November 28, 2011, the LPN Unit Manager was not informed by "any nursing staff" of the sexual assaults on resident #1 and #2 by resident #5's son.  
Continued interview with the LPN Unit Manager revealed, "A CNA told me about an issue over the weekend and asked if I had been informed...did not give specifics...said she'd been told not to tell."  
Continued interview with the LPN Unit Manager confirmed the alleged male perpetrator was in the facility on Monday, November 28, 2011.  
Interview on December 1, 2011, at 12:55 p.m., in the office, with LPN #5 (A wing on 7:00 a.m.-3:00 p.m. shift) confirmed LPN #5 was "never given any information Monday morning (November 28, 2011)...We had no clue..." (of the sexual assault).  
Continued interview with LPN #5 confirmed LPN #5 learned of the sexual assault from a CNA.  
The LPN stated, "We were appalled...Just put our patients at risk and we had no idea...I was in shock he was in the building and why no one told us about the situation...A couple of CNAs said they were told they would lose their job if they told anyone..."  
Interview on December 1, 2011, at 1:20 p.m., in the office, with LPN #8 (on duty 7:00 a.m.-3:00 p.m. shift on TCC (Transitional Care Center) unit November 28, 2011) confirmed LPN #8 was given no information on Monday, November 28, 2011, about the sexual assaults.  
Continued interview with LPN #8 revealed the LPN was told by the ADON on Tuesday, November 29, 2011, to...|

| F 225            |                                                                  |                     |

#### Deficiencies

**Category:** F 225  
**Location:** A Wing  
**Date:** 12/15/2011  
**Date Survey Completed:** 04/24/2012

**Name of Provider or Supplier:** Colonial Hills Nursing Center  
**Address:** 2034 Cochran Rd, Maryville, TN 37803

**State of CLIA Identification Number:** 445181
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
</table>
| F 225         | F 225         | "watch for" (alleged male perpetrator) but "didn't tell me what to do if I saw him."

Interview on December 1, 2011, at 1:30 p.m., in the office, with LPN #9 (LPN on duty 7:00 a.m. -3:00 p.m. shift on C wing November 28, 2011) confirmed the LPN was given no information on Monday, November 28, 2011, about the sexual assault. Continued interview with LPN #9 confirmed LPN #9 was not given any information about the alleged male perpetrator until Tuesday, November 29, 2011. The LPN reported being told on Tuesday to "Be on the lookout for him, and if you see him, call 911."

Interview on December 1, 2011, at 1:30 p.m., in the office, with LPN #10 (LPN on duty 7:00 a.m. -3:00 p.m. shift on B wing November 28, 2011) confirmed the LPN was given no information on Monday, November 28, 2011, about the sexual assault. Continued interview with LPN #10 confirmed LPN #10 was not given any information about the alleged male perpetrator until Tuesday, November 29, 2011. The LPN reported being told on Tuesday to "Be on the lookout for him, and if you see him, call the police."

Interview on December 1, 2011, at 3:20 p.m., in the office, with CNA #4 confirmed CNA #4 (who worked 3:00 p.m.-11:00 p.m. shift on Saturday and Sunday, November 26 and 27, 2011 on A Wing) saw CNA #1 and "...(CNA #1) was upset but couldn't talk about it...was real shaky...We were told there had been an incident with (resident #1) and (resident #5's) son." Continued interview with CNA #4 confirmed the alleged male perpetrator was in the facility on Sunday, November 27, 2011. Continued interview...
F 225 Continued From page 29
confirmed CNA #4 had "not seen him sober but rarely...always seemed intoxicated and couldn't ever find (resident #5) but she always sits in the same place all the time. He forgets where her room is." CNA #4 stated, "I don't know why he was here Sunday or Monday. I don't understand."

Interview on December 5, 2011, at 7:30 a.m., in the office, with the spouse of resident #1 confirmed the alleged male perpetrator was back in the facility on Sunday, November 27, 2011, and "no workers were anywhere around." Continued interview revealed the spouse had entered the facility on December 5, 2011, at 6:30 a.m. The spouse reported he entered the code posted on the front door, entered the facility with no employees in the area, and stated, "He (alleged perpetrator) could come in anytime if he had a mind to..."

Review of the scheduled hours and interview with the receptionist on December 5, 2011, at 9:05 a.m. at the receptionist's window revealed the reception area was not staffed until 8:30 a.m., Monday through Friday and 9:00 a.m., on Saturday and Sunday.

Interview in the office on December 5, 2011, at 10:30 a.m., with the RVP, the Regional Director of Clinical Services (RDCS) and the Director of Nursing (DON) confirmed resident #1 and resident #2 were sexually assaulted on Saturday, November 26, 2011, "around" 6:00 p.m. Continued interview with the RVP, the RDCS and the DON confirmed after resident #1 was sexually assaulted and removed from the café area, other female residents were left at the table with the alleged male perpetrator and placed at risk for
### F 225

Continued From page 30

sexual assault. Continued interview with the RVP, the RDCS and the DON confirmed resident #2 was sexually assaulted after resident #1 was sexually assaulted and removed from the area. Continued interview with the RVP, the RDCS and the DON confirmed the alleged male perpetrator was not removed from the facility after sexually assaulting residents #1 and #2 and confirmed the alleged male perpetrator returned to the facility on Sunday, November 27, 2011. Continued interview with the RVP, the RDCS and the DON confirmed the alleged male perpetrator returned to the facility on Monday, November 28, 2011; however the RVP, the RDCS and the DON denied being informed the alleged perpetrator had entered the room of resident #2 on Monday, November 28, 2011. Continued interview with the RVP, the RDCS and the DON confirmed the Administrator, the ADON and the RN Weekend Supervisor (RN #1) were informed of the sexual assault on Saturday, November 26, 2011, but the Administrator, the ADON and RN #1 all failed to initiate an investigation of the assaults. Continued interview with the RVP, the RDCS and the DON confirmed Law Enforcement and the State agency were not notified within twenty-four hours of the sexual assault as required by Federal regulations, facility policy and the Elder Justice Act. Continued interview with the RVP confirmed the Administrator did not notify the RVP of the assaults on November 26, 2011, and if the Administrator had notified the RVP, the RVP "could have walked (Administrator) through the process." Continued interview with the RVP and the RDCS confirmed the RDCS, the corporate office, and the RVP were not notified of the sexual assaults until Monday, November 28, 2011, in the “afternoon.” Continued interview with
Continued From page 31

the DON confirmed the DON was not notified of the sexual assaults on November 26, 2011, and had no knowledge of the assaults until the former Administrator called the DON at home "late in the afternoon" on Monday, November 28, 2011, and began inservicing the DON on abuse. The DON asked the former Administrator if something had happened, and was then informed of the sexual assaults. Continued interview confirmed the entrance doors at the front and on the TCC unit were locked from 8:00 p.m. until 6:00 a.m., and no one could enter the posted code and enter the facility. Continued interview confirmed between 6:00 a.m., and 8:00 a.m., the posted code could be entered at the front entrance, and anyone could enter the facility undetected because the reception area was not staffed until 8:00 a.m.

Review of a "time line" provided by the Regional Vice President (RVP) on December 7, 2011, at 9:05 a.m., revealed on Monday, December 5, 2011, the facility established a contract with a security company to provide security for the facility from 8:00 p.m., to 6:00 a.m. The security guard was initiated on December 5, 2011, at 10:00 p.m.

Interview on December 5, 2011, from 1:30 p.m. -2:30 p.m. in the office, with the Director of Social Services (DSS) confirmed the DSS "first learned" of the sexual assaults of residents #1 and #2 on Monday, November 28, 2011. The DSS reported the former Administrator gave the DSS written statements (interviews with resident #1 and #2 on November 26, 2011 by RN #1) and asked the DSS to follow up. The DSS interviewed both residents. Continued interview with the DSS revealed the DSS went to the former
**NAME OF PROVIDER OR SUPPLIER**

COLONIAL HILLS NURSING CENTER

<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>
</tr>
</thead>
<tbody>
<tr>
<td>F 225</td>
<td>Continued From page 32</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Administrator on November 28, 2011, "around" 11:30 a.m., to 12:30 p.m., and informed the Administrator, "We have a problem. We need to call the police" and reported to the Administrator the two residents had been sexually assaulted. Continued interview with the DSS revealed the Administrator told the DSS, "Don't start throwing the word sexual assault around. Don't get over excited." Continued interview with the DSS confirmed the Administrator "was not responding." The DSS informed the RDCS of the sexual assault. The RDCS informed the corporate office and was directed to notify Law Enforcement. Continued interview with the DSS revealed, "I was very pleased Corporate took this seriously. (Administrator) did not take it seriously."

Telephone interview on December 5, 2011, at 5:00 p.m., with the former Administrator (Administrator at the time of the sexual assaults) confirmed the Administrator was notified on Saturday, November 26, 2011, at 6:20 p.m., by the ADON that resident #5's son had touched the arm and leg of two residents. Continued interview with the former Administrator confirmed the ADON informed the Administrator the alleged male perpetrator was "intoxicated" and making residents nervous. Continued interview with the former Administrator confirmed the Administrator did not direct the ADON to escort the alleged male perpetrator from the facility and did not direct the ADON to notify Law Enforcement of the sexual assaults.

Telephone interview on December 5, 2011, at 5:20 p.m., with the ADON confirmed CNA #1 informed the ADON on Saturday, November 26,
<table>
<thead>
<tr>
<th>F 225</th>
<th>Continued From page 33</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011, at 6:00 p.m., that resident #5's son had touched the leg of resident #1; the resident was uncomfortable; and CNA #1 had removed the resident from the café area. Continued interview with the ADON confirmed resident #2 was sexually assaulted after resident #1 was removed from the area and confirmed the alleged male perpetrator was left in the café area with three other residents after he assaulted resident #1. The ADON confirmed, &quot;There was a lag time when transported (resident #1) and when (resident #2) was assaulted.&quot; Continued interview with the ADON revealed the ADON directed RN #1 to interview both residents, and &quot;That was the last I heard of it.&quot; Continued interview with the ADON confirmed the ADON notified the Administrator of the sexual assaults on November 26, 2011, and was directed by the Administrator to not complete an Incident report or notify Law Enforcement, the DON or the corporate office. Continued interview with the ADON confirmed RN #1 interviewed residents #1 and #2; however the ADON was in the facility conducting audits; was not scheduled to work on November 26, 2011, and &quot;went home&quot; without knowing the results of the interviews. Telephone interview on December 5, 2011, at 5:50 p.m., with RN #1 confirmed resident #1 and #2 were sexually assaulted by the son of resident #5 on Saturday, November 26, 2011. Continued interview with RN #1 confirmed RN #1 interviewed both residents about the assault on Saturday, November 26, 2011, and confirmed the written statement by RN #1 November 29, 2011, that both residents were sexually assaulted. Continued interview with RN #1 confirmed RN #1 did not notify the Administrator or the ADON of...</td>
<td></td>
</tr>
</tbody>
</table>
Continued From page 34

the results of the interviews with residents #1 and #2. Continued interview with RN #1 revealed the ADON told RN #1 to put the interview statements in the Administrator's mail box.

Interview on December 7, 2011, at 10:30 a.m., in the dining room, with the Director of Nursing (DON) confirmed no residents (except for residents #1 and #2) were interviewed after the sexual assaults occurred on November 26, 2011, to determine if other residents had been assaulted. Continued interview confirmed no other residents were interviewed until November 29, 2011, (three days after the assaults). Continued interview with the DON confirmed residents #1 and #2 were not physically assessed for signs of sexual assault or injury until November 28, 2011, (two days after the assault took place on November 26, 2011).

Interview on December 8, 2011, at 9:45 a.m., in the dining room, with the Director of Nursing confirmed physical assessments were not performed on any female residents after the sexual assaults on November 26, 2011, to ensure no other female residents had been sexually assaulted by the alleged male perpetrator.

Interview on December 15, 2011, at 12:40 a.m., with resident #15, in the resident's room, revealed, "They've locked the doors and I hear the door bell ring all night. People can't get in and they ring that bell 24/7 (twenty-four hours a day, seven days a week). Nurses don't have time to go answer the door all night long. If they stick something in it, an alarm goes off." Continued interview revealed family members of the resident had observed "stuff stuck" in the smoking entry...
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 225</td>
<td></td>
<td></td>
<td>Continued From page 35</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>door to keep it unlocked. Continued interview revealed a CNA had told the resident the &quot;Fire Marshall&quot; had found the door propped open.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Interview on December 15, 2011, at 1:25 p.m., in the conference room, with the RVP confirmed the security guard &quot;found&quot; the door to the smoking area propped open at 9:15 p.m., on December 13, 2011. Continued interview with the RVP revealed the facility had installed on December 14, 2011, at 6:30 a.m., an alarm on the door to the smoking area which sounded if the door was opened for thirty seconds.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Interview on December 15, 2011, at 2:00 p.m., in the conference room, with the RVP confirmed staff had observed the alleged male perpetrator in the parking lot, &quot;driving around.&quot; Continued interview revealed the RVP was in the facility at 9:00 p.m., on December 14, 2011, when the security guard asked the RVP to watch as the security guard approached a car with a man inside, parked in the parking lot. The RVP reported the man told the security guard he was there &quot;watching the moon come over the ridge.&quot; The security guard directed the man to leave the facility's property. The RVP reported &quot;feeling&quot; the man in the parking lot was the alleged male perpetrator of the sexual assaults. Continued interview revealed the security guard had a picture of the alleged male perpetrator but could not identify him with certainty because the man was wearing a ball cap and never looked at the security guard. Continued interview revealed no staff had been inserviced NOT to prop doors open.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Interview on December 15, 2011, at 2:25 p.m., in</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SUMMARY STATEMENT OF DEFICIENCIES

F 225 Continued From page 36

the conference room, with the Maintenance Director confirmed none of the doors in the facility, except for the door to the smoking area, had an alarm which would sound an alert if the doors were propped open.

The Administrator, the ADON and the RN (#1) weekend Supervisor had knowledge on Saturday, November 26, 2011, of the sexual assault on two residents (#1 and #2) and put no measures in place to protect other female residents from assault by the alleged male perpetrator; failed to immediately remove the alleged male perpetrator from the facility; and failed to ensure the alleged male perpetrator did not return to the facility. The alleged male perpetrator returned to the facility on Sunday, November 27, 2011, and on Monday, November 28, 2011. He was removed from the room of resident #2 on November 28, 2011. The facility failed to immediately assess residents #1 and #2 for harm resulting from the sexual assault and failed to immediately assess or interview other female residents to ensure they had not been harmed by the alleged perpetrator.

The Director of Nursing, the Regional Director of Clinical Services and the Regional Vice President were not informed of the sexual assault which occurred on Saturday, November 26, 2011, until two days later, on November 28, 2011. Law Enforcement and the State agency were not notified as required.

Staff who came on duty on Monday, November 28, 2011, on 7:00 a.m., to 3:00 p.m., shift were given no information about the sexual assaults which occurred on Saturday, November 26, 2011, and were given no information on steps to take if
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 225</td>
<td>Continued From page 37</td>
<td>the alleged male perpetrator returned to the facility. The facility failed to secure all doors to prevent the alleged male perpetrator from entering the facility after sexually assaulting two residents. Refer to F223 Substandard Quality of Care C/O #28971</td>
<td>F 225</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 281</td>
<td></td>
<td>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on review of the Tennessee Nurse Practice Act, and interview, the facility failed to ensure orders for labwork and treatments were obtained from an authorized individual. The findings included: Review of 63-7-103, &quot;Practice of professional nursing &quot; defined. - (a) (1) &quot; Practice of professional nursing &quot; means the performance for compensation of any act requiring substantial specialized judgment and skill based on knowledge of the natural, behavioral and nursing sciences, and the humanities, as the basis for application of the nursing process in wellness and illness care. (2) &quot; Professional nursing &quot; includes: (A) Responsible supervision of a patient requiring</td>
<td>F 281</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Continued From page 38

skill and observation of symptoms and reactions and accurate recording of the facts;

(B) Promotion, restoration and maintenance of health or prevention of illness of others;

(C) Counseling, managing, supervising and teaching of others;

(D) Administration of medications and treatments as prescribed by a licensed physician, dentist, podiatrist or nurse authorized to prescribe pursuant to 63-7-123.

Interview with Registered Nurse (RN) #4 on December 8, 2011, at 6:00 p.m., in the dining room confirmed on November 23, 2011, during supper, residents were not eating their beets and became aware the beets were too salty.

"Residents' #6, #7, #8, #9, #10, #11, #12 had vomiting, ...the ED (Administrator, also known as the Executive Director) called me, explained to have talked with the (Medical Director) and the ED gave me orders that (Medical Director) wanted anyone vomiting after supper to push fluids for the next 24 hours and a Basic Metabolic Panel (BMP) on Friday; and to consider this an incident." When Registered Nurse #4 was asked by the surveyor if the ED was a licensed nurse or physician, the RN stated, "No, I took the orders from the ED, who is not a nurse or doctor."

Telephone interview on December 12, 2011, with the Administrator of record on November 23, 2011, stated, "I called the Medical Director on November 23, 2011 around 9:30 p.m., to report the incident of the salt used as thickener in the beets for dinner; (Medical Director) said to control any adverse affects from the salt, to control the vomiting and push fluids, to get a BMP on Friday to evaluate the sodium," and that "Dr. (Medical
**NAME OF PROVIDER OR SUPPLIER**

**COLONIAL HILLS NURSING CENTER**

<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>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 281</td>
<td>Continued From page 39 Director's name) was concerned the sodium levels would be elevated from too much salt and residents may need intravenous fluids and residents would have potential issues:&quot; Continued interview confirmed, &quot;I notified the 3:00 p.m.-11:00 p.m. Registered Nurse Supervisor (Registered Nurse #4) and gave the orders.&quot; Telephone interview with the Medical Director on December 12, 2011, at 1:20 p.m., confirmed the Administrator notified the Medical Director of the salted beets on November 23, 2011, between 9:30 p.m.-9:50 p.m. Continued interview confirmed the Medical Director did not speak with a nurse or nursing administration. C/O #28971</td>
<td>F 281</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 309</td>
<td>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, 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, review of hospital medical records, review of facility investigation records, review of facility policy, review of a vendor invoice, review of menus,</td>
<td>F 309</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**NAME OF PROVIDER OR SUPPLIER:**

**COLONIAL HILLS NURSING CENTER**

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

2034 COCHRAN RD

MARYVILLE, TN 37803

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID 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>
</tr>
</thead>
<tbody>
<tr>
<td>F 309</td>
<td>Continued From page 40 review of a food recipe, and interview, the facility failed to ensure food ingredients were stored in correct containers; failed to ensure licensed nurses received orders from the licensed physician; and failed to prepare and serve resident food according to menu, by adding approximately twenty-five pounds of salt to twelve pounds of pureed beets. Seven residents (#6, #7, #8, #9, #10, #11, #12) of fifteen residents reviewed ate the salted beets and suffered a negative outcome. The facility's failure resulted in critical sodium and chloride levels for two residents (#6, #7), requiring hospital treatment; resulted in elevated sodium and chloride levels for resident #8, requiring intravenous fluids; and resulted in elevated sodium and chloride levels for residents #9, #10, #11, #12, requiring increased oral &quot;pushed&quot; fluids. The facility's failure placed residents #6, #7, #8, #9, #10, #11, #12 in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment or death). A meeting was held on December 15, 2011, at 4:45 p.m., in the Conference Room, with the Director of Nursing/Interim Administrator, Regional Director of Clinical Services, Corporate Director of Clinical Services, Regional Vice President, and Divisional Vice President to inform the facility of the Immediate Jeopardy. The Immediate Jeopardy was effective November 23, 2011. Observation, review of in-service records, and interviews revealed the facility took corrective measures which removed the Jeopardy effective</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 309</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
F 309 Continued From page 41

December 6, 2011. The deficient practice continues at an "E" level until all corrections have been monitored and evaluated for effectiveness.

The findings included:

Review of a facility invoice from a food vendor dated November 22, 2011, revealed one twenty-five pound bag of granulated, plain salt was delivered to the facility.

Review of the facility Dinner Menu dated November 23, 2011; revealed pureed beets were on the menu.

Review of a food vendor recipe "Pickled Beets PU (puree)" dated November 29, 2011, at 8:31:40 a.m., revealed, "...Yield: 65 portions...Portions: 65...Ingredients and Instructions...Pickled beets - 65 ½ (sixty-five and one-half) cup...Food thickener - 1 ¼ (one and one-fourth) Cup 2 Tablespoon (one and one-fourth cup, plus two tablespoon). "Recipe instructions provided to dietary prior to November 23, 2011," handwritten below the instructions of the recipe.

Review of a facility policy "Food Preparation" dated as last revised: January 1, 2007, revealed, "...Guidelines: Menu items are prepared according to the menu, production sheets and recipes..."

Review of a facility investigation statement dated November 24, 2011, by the Assistant Dietary Manager revealed, at approximately 2:30 p.m., on November 22, 2011, the Assistant Dietary Manager instructed a Dietary Aide #1 to put the "stock" (dietary supplies) up. On November 23,
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

| (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445181 |
| (X2) MULTIPLE CONSTRUCTION |
| A. BUILDING |
| B. WING |
| (X3) DATE SURVEY COMPLETED C 12/15/2011 |

NAME OF PROVIDER OR SUPPLIER
COLONIAL HILLS NURSING CENTER

<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>
</tr>
</thead>
<tbody>
<tr>
<td>F 309</td>
<td>Continued From page 42 2011, Cook #1 prepared pureed beets with an ingredient Cook #1 assumed to be a thickening agent, but the beets would not thicken. Cook #1 informed the Assistant Dietary Manager the beets would not thicken and the Assistant Dietary Manager instructed Cook #1 to heat the beets in the oven (the Dietary Manager thought the beets were cold and heating them would help with the thickening process). The beets were heated in the oven and were thick. Thinking the problem with thickening the beets was &quot;fixed,&quot; the tray line was started for supper (dinner). The Assistant Dietary Manager went to the dry-stock room (supply room for unrefrigerated food items such as condiments, seasonings and canned goods) to finish putting up the stock that arrived on November 22, 2011. As the tray line was nearing the end, the Assistant Dietary Manager was notified of a resident complaint that the beets were &quot;too salty.&quot; The tray line ended at approximately 5:30 p.m. Just as the Assistant Dietary Manager was finishing putting up the remaining stock, it was noticed the salt bin had not been filled (was empty). The Assistant Dietary Manager recalled Dietary Aide #1 asking where the salt went when putting up the stock on November 22, 2011. The Assistant Dietary Manager recalled instructing to &quot;put the salt in the white container by the seasonings.&quot; The Assistant Dietary Manager then realized Dietary Aide #1 had put the salt in the thickener bin, not the salt bin. Review of a facility investigation statement (no date), by Dietary Aide #1 revealed, &quot;...I was putting up the truck (delivered dietary supplies) and I put the salt in the thickener box, and I didn't know it was the thickener box. The next day</td>
</tr>
<tr>
<td>F 309</td>
<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
</tr>
<tr>
<td>F 309</td>
<td></td>
</tr>
</tbody>
</table>

STREET ADDRESS, CITY, STATE, ZIP CODE
2034 COCHRAN RD
MARYVILLE, TN 37803

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2012
FORM APPROVED
OMB NO. 0938-0391

If continuation sheet Page 43 of 80
Cook #1 used the thickener to make puree and didn't know it was salt instead of thickener. It wasn't thickening so Cook #1 kept adding more and more...The Assistant Dietary Manager asked which bucket I put the salt and I told the Assistant Dietary Manager the clear one and we went back there. I pointed out the one I put the salt into and then the Assistant Dietary Manager showed me where the salt was supposed to go."

Review of a facility investigation statement dated November 24, 2011, by Cook #1 revealed, "...we have a bin that is used to store our food thickener (thickener). I went to the bin and proceeded to get...what I believed to be thickener. I then proceeded to use it in my beets...They didn't seem to thicken...Unfortunately I failed to stop and taste the food I was making which could have prevented a disaster. We went on to serve dinner. At the end my manager approached me and ask, "Did you put salt in the beets?" I replied, "No"...To my knowledge the Assistant Dietary Manager ask Dietary Aide #1(about putting the salt in the wrong bin) and Dietary Aide #1replied "yes"...By this time all the food carts had already been on the floor. I know that if I would have tasted my food, as I will be doing from now on, I could have prevented this life threatening mistake. This will from now on be an important part of my routine."

Interview with Cook #1 on December 7, 2011, at 4:35 p.m., in the dining room confirmed Cook #1 used salt to thicken the pureed beets for dinner on November 23, 2011. "I know the difference between salt and thickener, but when I pureed and thickened the beets, I didn't follow the recipe, and I didn't pay attention to the actual substance..."
F 309 Continued From page 44

in the thickener bin...As long as I've worked here the thickener bin has never been labeled...I did not realize I had thickened the beets with salt until the residents became sick after eating supper (dinner)."

Review of the facility's laboratory reference results, provided by the hospital included the following normal ranges for a Basic Metabolic Panel (BMP-a set of blood chemical tests) and Chem 7 (a set of blood chemical tests):

- Glucose (a measure of sugar in the blood): 80-105
- Blood Urea Nitrogen (BUN- a waste product formed in the liver and collects in the bloodstream; patients with kidney failure have high BUN levels): 8-22
- Creatinine (measures kidney function): 0.70-1.20
- Sodium (an electrolyte in the blood): 137-145
- Chloride (an electrolyte in the blood): 98-107

Resident #6 was admitted to the facility on March 8, 2011, with diagnoses including Dementia, Congestive Heart Failure, Chronic Kidney Disease, Hypertension, and History of Cardiovascular Accident (Stroke).

Medical record review of a Minimum Data Set dated October 25, 2011, revealed the resident had short and long-term memory problems with severely impaired cognition skills for daily decision making. Continued review revealed the resident was totally dependent with eating and had to be fed by staff.

Medical record review of the Physician's Recapitulation Orders dated November 1, through November 30, 2011, revealed, "...Pureed
F 309 Continued From page 45
diet with honey-thick liquids..."

Medical record review of the Monthly Meal Intake report revealed, "...November 23, 2011...Dinner: 100% (percent)...". Continued review revealed, "Ate 100% of beets" handwritten on the bottom of the report.

Medical record review of a nurse's note dated November 23, 2011, at 8:00 p.m., revealed the resident vomited three times after supper, had a blood pressure of 170/82, and was administered Phenergan (for nausea and vomiting) 25 milligrams intramuscularly in the right upper thigh. At 9:00 p.m., the family was notified and at 9:30 p.m., the physician was notified, with telephone orders to "push fluids for 24 hours and a BMP on Friday (November 25, 2011)". Continued review revealed 11:20 p.m. the vomiting continued, more Phenergan (25 milligrams intramuscularly) was administered, and a nursing assessment revealed, "...rales and rhonchi bilaterally (abnormal breath sounds in both lungs)...blood pressure 159/99; pulse 110; respiration 24; temperature 98.5 (degrees); oxygen saturation 70% (the amount of oxygen bound to hemoglobin in the blood, with the normal range being 95-100%)...oxygen at 4 liters and increased to 5 liters via mask..."

Continued review of the medical record revealed the following: A nurse's note dated November 24, 2011, revealed the nurse practitioner was notified of the resident's condition at 12:00 a.m., (midnight). Review of orders received (by telephone) revealed: Rocephin (antibiotic) 1 gram intramuscularly now; start intravenous fluids (fluids in the vein) of Normal Saline at 100
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 309</td>
<td></td>
<td></td>
<td>Continued From page 46 milliliters per hour (one liter); Levaquin (antibiotic) 500 milligrams intravenously for seven days; Albuterol nebulizer treatments (breathing treatments) every six hours routinely for seven days and as needed for shortness of breath...diagnosis Pneumonia.</td>
<td>F 309</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medical record review of a nurse's note dated November 24, 2011, at 2:00 a.m., revealed: the resident's blood pressure was 184/104; pulse 118; respirations 24; and oxygen saturation was 94%; the nurse practitioner was notified and orders were received for Clonidine 0.1 milligrams by mouth (one time) for the elevated blood pressure. Continued review revealed at 8:00 a.m., the blood pressure had dropped to 133/73, and the resident's temperature, was 99 degrees.

Medical record review of a nurse's note dated November 24, 2011, at 10:00 a.m., revealed the resident's blood pressure and temperature both were elevated at 151/79 and 100.6, respectively. Continued review of the nurse's notes revealed at 10:10 a.m., the physician was notified and telephone orders for an x-ray and labs were received as follows: stat (immediately) portable chest x-ray, rule out Pneumonia; stat CBC (complete blood count - basic evaluation of the red and white cells, and platelets in the plasma); Chem 7; and a B-Peptide (BNP-brain natriuretic peptide-a heart failure blood test). The stat chest x-ray was obtained at 10:55 a.m., and review of the Radiology Report revealed, "...Mild patchy left lung air-space densities compatible with Pneumonia. In comparison to prior study, findings are new..." Review of the lab report revealed the labs were drawn and at 11:34 a.m., and the lab notified the nursing home of a critical
Continued From page 47
sodium value of 170 and chloride value of 137;
additional abnormal levels included:
BUN: 41
Creatinine: 1.9
BNP: 2083.6 (normal range: 5-100)
Chest x-ray: "...left basilar atelactasis/infiltrate..."

Continued review of the nurse's notes dated November 24, 2011, revealed the physician was paged at 11:45 a.m., regarding the critical labs and at 12:30 p.m., telephone orders were received, "To ER (emergency room) now."

Medical record review revealed no documentation of a completed nursing home transfer form to the hospital regarding the November 24, 2011, transfer to the emergency room.

Medical record review of a hospital physician's History and Physical report dated November 24, 2011, revealed the resident was sent from the nursing home for evaluation of abnormal lab tests. Continued review revealed, "...I assume these mean sodium and chloride in particular (medical record review revealed no documentation of a completed nursing home transfer form to the hospital regarding the resident's transfer to the emergency room or the consumption of salted pureed beets on November 23, 2011). BMP was done this morning which showed a BUN of 41, creatinine 1.9...sodium 170, chloride 137...had not been responsive today. There is no other history available. It is noted on November 14, 2011, (patient) had a sodium of 139 with chloride 106, BUN 37, and creatinine 1.4, so (patient) is profoundly dehydrated. When (patient) arrived in the emergency room, chest x-ray showed that (patient) had Pneumonia..." Continued review revealed, "...appeared to be chronically ill,
Continued From page 48

demented (patient) who was profoundly dehydrated and unresponsive...pharynx dry, mouth dry, nasal passages dry...Laboratory: urinalysis showed greater than 51 white blood cells (normal range: negative), creatinine 1.9, sodium 171, chloride 143, BNP was 2083...Impression: Pneumonia with Sepsis; Possible Urinary Tract Infection; Dehydration with Hypernatremia (high blood sodium), Hyperchloremia (high blood chloride); Acute Injury on top of Chronic Kidney Disease; History of Congestive Heart Failure...Plan: Try to control combination of Congestive Heart Failure and Acute Kidney Injury...(the patient's) prognosis is very poor..."

Medical record review of a Cardiology Consult dated December 4, 2011, revealed, "...(nursing home) reported (patient) was doing okay, to their knowledge, until the night before Thanksgiving (November 23, 2011) when (patient) began vomiting and aspirated...An echocardiogram was done on November 27, 2011, and showed an ejection fraction of 25%..."

Medical record review of a hospital Discharge Summary, dated November 30, 2011, and addended on December 9, 2011, revealed, "...Admission Date: November 24, 2011, Discharge Date: December 9, 2011...Diagnosis: Acute Aspiration Pneumonia; Urinary Tract Infection; Dehydration; Hypernatremia; Hyperchloremia; Acute Kidney Injury; Fluid Retention; Hypertension; and Congestive Heart Failure...(patient) was placed in the hospital and was certainly unresponsive initially...could not be fed orally...all medications changed to IV (intravenous)...were able to culture out (patient's) sputum, which showed Escherichia coli and

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 309</td>
<td>Continued From page 48</td>
<td>demented (patient) who was profoundly dehydrated and unresponsive...pharynx dry, mouth dry, nasal passages dry...Laboratory: urinalysis showed greater than 51 white blood cells (normal range: negative), creatinine 1.9, sodium 171, chloride 143, BNP was 2083...Impression: Pneumonia with Sepsis; Possible Urinary Tract Infection; Dehydration with Hypernatremia (high blood sodium), Hyperchloremia (high blood chloride); Acute Injury on top of Chronic Kidney Disease; History of Congestive Heart Failure...Plan: Try to control combination of Congestive Heart Failure and Acute Kidney Injury...(the patient's) prognosis is very poor...&quot;</td>
<td>F 309</td>
<td></td>
</tr>
<tr>
<td>ID</td>
<td>PREFIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>ID</td>
<td>PREFIX TAG</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>
| F 309 | Continued From page 49 methicillin-resistant Staphylococcus aureus...initially placed on Vancomycin (antibiotic) but there was some issue about (patient's) kidney failure as (patient) was initially dehydrated when (patient) came in...switched to Zyvox (antibiotic) to protect kidney function...Hospital Course: Basically this was an 82-year-old...demented patient from (nursing home) who came in with Acute Pneumonia, Sepsis, Dehydration, Hypernatremia, and Hyperchloremia and was admitted for rehydration and treatment of Pneumonia...started on broad spectrum antibiotics...cultured and seen by Speech Therapy...difficulty swallowing...had a modified barium swallow which showed (patient) could not safely swallow any materials...did not eat well and had no appetite, would not take medication or food or water...electrolytes were replaced toward normal...grew out methicillin-resistant Staphylococcus aureus and Escherichia coli on (patient's) Pneumonia and finished a course of antibiotics for that...developed Diarrhea and Augmentin was stopped and developed a fever...this change in antibiotics proved useful and the diarrhea and fever went away...had an Acute Myocardial Infarction and was seen by a Cardiologist...started on Diltiazem drip...continued steadily downhill course...with palliative care and all the physicians, family decided that they wanted comfort care only..." Continued review revealed (patient) remained in the hospital for three more days on comfort care then was discharged back to the nursing home for comfort care measures. Medical record review of an Admission Nursing Assessment dated December 9, 2011, at 3:30 p.m., revealed, "...Diagnoses-Pneumonia (comfort care only)...If Admitted to the Hospital in...
<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>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
</table>
| F 309 | Continued From page 50  
Last 30 Days, Why- Pneumonia...  
Medical record review of a nurse's note dated December 9, 2011, at 3:30 p.m., revealed, "...readmitted...was diagnosed with Pneumonia and decreased status with orders for comfort care measures..."  
Medical record review of a nurse's note dated December 11, 2011, at 3:00 a.m., revealed the resident's temperature was elevated at 102.2 degrees and had a non-productive cough. Tylenol and cold compresses were administered symptomatically. Continued review revealed the resident's vital signs ceased and the resident expired at 7:45 a.m.  
Telephone interview with Certified Nursing Assistant #3 on December 13, 2011, at 10:00 a.m., confirmed Certified Nursing Assistant #3 was assigned to care for resident #6 on November 23, 2011, and assisted resident #6 to eat supper. Certified Nursing Assistant #3 stated, "ate 100% of the beets and had a large amount of projectile vomiting three times...(resident) couldn't stop...(resident) looked so pitiful..."  
Interview with the Registered Dietician on December 8, 2011, at 10:15 a.m., in the dining room confirmed the recipe for thickening the pureed beets on November 23, 2011, was not followed. "The nausea and vomiting the resident experienced was a precursor to a problem...the amount of salt in the pureed beets caused an electrolyte imbalance and could cause kidney damage...the salted beets contributed to resident #6's Acute Kidney Injury." | F 309 | |
<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>(X4) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 309</td>
<td>Continued From page 51 Telephone interview with the Cardiologist on December 14, 2011, at 6:01 p.m., confirmed the resident #6 had a cardiac ejection rate of 25% and stated &quot;The salted beets definitely would not be good on an ejection rate of 25%.&quot; Telephone interview with the Medical Director on December 12, 2011, at 1:20 p.m., confirmed the Administrator notified the Medical Director of the salted beets on November 23, 2011, between 9:30 p.m. - 9:50 p.m. Continued interview confirmed the Medical Director did not speak with a nurse or nursing administration. The Administrator informed the Medical Director that a large amount of salt had been inadvertently mixed with pureed beets and &quot;introduced&quot; to several residents who were experiencing symptoms. Continued interview confirmed the Medical Director stated, &quot;The level of an individual's health affects the degree of the ability to compensate...it is concerning, and could be life-threatening&quot; When the surveyor asked if Chronic Kidney Disease, as resident #6 has, the Medical Director confirmed, &quot;yes; resident #6 would be an individual that would be predisposed making this a life-threatening situation.&quot; The Medical Director stated &quot;the salted beets were dangerous and something you would not want to happen again.&quot; Continued interview with the Medical Director on December 15, 2011, at 10:30 a.m., in the conference room confirmed, &quot;...the resident received too much salt and experienced nausea and vomiting secondary to the salt...the Acute Renal Injury was secondary to Azotemia, resulting from an intracellular shift of fluid, which reduced fluid flow to the kidneys...&quot;</td>
<td>F 309</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Resident #7 was admitted to the facility on February 5, 2007, with diagnoses including Dementia and Hypertension.

Medical record review of a Minimum Data Set dated October 11, 2011, revealed the resident had short and long-term memory problems with severely impaired cognition skills for daily decision making. Continued review revealed the resident was totally dependent with eating and had to be fed by staff.

Medical record review of the Physician's Recapitulation Orders dated November 1, through November 30, 2011, revealed, "...Pureed diet with nectar-thick liquids..."

Medical record review of the Monthly Meal Intake report revealed, "...November 23, 2011...Dinner: 50%..." Continued review revealed, "Ate 4 (four) bites of beets" handwritten on the bottom of the report.

Medical record review of a nurse's note dated November 23, 2011, at 8:00 p.m., revealed the resident vomited a large amount after supper. At 9:30 p.m., the physician was notified, with telephone orders to "push fluids for 24 hours and a BMP on Friday (November 25, 2011)," and at 10:20 p.m., the family was notified of the resident's condition.

Continued review of the nurse's notes dated November 25, 2011, revealed the Basic Metabolic Panel was drawn (at 6:04 a.m.) and at 8:20 a.m., the lab notified the nursing home of a critical sodium value of 161 and chloride value of...
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

COLONIAL HILLS NURSING CENTER

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREFIX</td>
<td>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>PREFIX</td>
<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td></td>
</tr>
<tr>
<td>TAG</td>
<td></td>
<td>TAG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 309</td>
<td>Continued From page 53</td>
<td>F 309</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>123; additionally, the BUN value was 26. The physician was paged regarding the critical labs and at 8:30 a.m., telephone orders were received to &quot;Transfer to (hospital) emergency room for evaluation...Diagnosis Abnormal Lab Values.&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical record review of a hospital physician's History and Physical report dated November 25, 2011, revealed, &quot;...93-year-old...with severe Alzheimer's disease...sent from (nursing home) for abnormal lab test...Reason for this is uncertain...has no obvious sepsis or vomiting, dehydration, or anything of that nature (medical record review revealed no documentation of a completed nursing home transfer form to the hospital regarding the resident's transfer to the emergency room or the consumption of salted pureed beets on November 23, 2011). As far as the (patient's) family knows (patient) has been eating and drinking in (patient's) normal fashion...Social History: lives at a local nursing home and is disabled and demented...Impression: Hypernatremia...&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical record review of a hospital Discharge Summary dated November 28, 2011, revealed a diagnosis of Hypernatremia. Treatment included intravenous hydration (the resident required intravenous fluids for three days to treat the Hypernatremia).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical record review of a nurse's note dated November 29, 2011, at 11:30 a.m., revealed the resident returned to the facility from the hospital on November 29, 2011 with a diagnosis of a Urinary Tract Infection.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical record review of a Nurse Practitioner</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### NAME OF PROVIDER OR SUPPLIER

**COLONIAL HILLS NURSING CENTER**

### SUMMARY STATEMENT OF DEFICIENCIES

**ID**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 309</td>
<td>Continued From page 54</td>
<td></td>
</tr>
</tbody>
</table>

Assessment dated November 30, 2011, revealed, "...Chief Complaint: Hospital return November 29. Treated for Hypernatremia...Gastrointestinal History: vomiting prior to admit to (hospital)...

Medical record review of a Physician's Progress Note dated December 1, 2011, revealed, "...Hospital return...Dehydration and Hypernatremia...No Urinary Tract Infection...Assessment: Hypernatremia (resolved)...Dehydration (resolved)...Hypertension..."

Resident #8 was admitted to the facility on January 21, 2011, and readmitted on February 14, 2011, with diagnoses including Altered Mental Status, Diabetes Mellitus, Urinary Tract Infection, and Dementia.

Medical record review of a Minimum Data Set dated November 1, 2011, revealed the resident had short and long-term memory problems with severely impaired cognition skills for daily decision making. Continued review revealed the resident required extensive assistance from staff with eating meals.

Medical record review of the Physician's Recapitulation Orders dated November 1, through November 30, 2011, revealed, "...Pureed diet..."

Medical record review of the Monthly Meal Intake report revealed, "...November 23, 2011...Dinner: 25%..." Continued review revealed, "Ate 100% of beets" handwritten on the bottom of the report.

Medical record review of a nurse's note dated...
### Summary Statement of Deficiencies

**F 309 Continued From page 55**

November 23, 2011, at 8:00 p.m., revealed the resident vomited after eating supper and the family was notified. At 9:30 p.m., the physician was notified, with telephone orders for a "BMP on Friday (November 25, 2011) and push fluids for 24 hours." At 11:30 p.m., the blood sugar was low (read "low" on glucometer); glucagon (raises the blood sugar) was administered, along with fortified pudding and one-half a cup of juice. The physician was notified and no new orders were received. The blood sugar was rechecked at 11:50 p.m., and was 70.

Medical record review of a nurse's note dated November 24, 2011, at 11:00 a.m., revealed antibiotics continued for Bronchitis (ordered on November 21, 2011) and continued to push fluids.

Medical record review of a lab report dated November 25, 2011, revealed the BMP was drawn at 6:15 a.m., with results as follows:
- Glucose: 73
- BUN: 37
- Creatinine: 1.2
- Sodium: 152
- Chloride: 118

Medical record review of a nurse's note dated November 25, 2011, revealed the physician was notified at 2:00 p.m., and orders were received to insert a peripheral intravenous line and give intravenous fluids one-half of normal saline at 60 milliliters per hours times two liters; a BMP (lab test) on Monday (November 28, 2011); and to push (oral) fluids - four ounces every two hours while awake for 48 hours. At 2:30 p.m., the intravenous line was placed, intravenous fluids

### Table: Provider's Plan of Correction

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID 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>
</tr>
</thead>
<tbody>
<tr>
<td>F 309</td>
<td>Continued From page 55</td>
<td>F 309</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID PREFIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>ID PREFIX TAG</td>
<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td>COMPLETION DATE</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>---------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>F 309</td>
<td>Continued From page 56 were started and the family was notified.</td>
<td>F 309</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medical record review of a Nurse Practitioner's Progress Note dated November 28, 2011, revealed the resident had not eaten all day and was not swallowing, and the blood sugar continued to be unstable; further review revealed an intake of two-liters of fluid over the weekend due to a sodium level of 152, Creatinine 1.2, and BUN of 37. "The resident is a brittle Diabetic and staff thought she got pureed food with extra salt." Assessed diagnoses included Dysphasia, Diabetes Type II/Hypoglycemia on insulin, End-Stage Dementia, Volume Depletion, and Hypernatremia. After discussion with the family, it was decided for the time being, to stop any unnecessary medications and see how (resident) does. The treatment plan was changed as follows: Intravenous fluids changed to Dextrose 50% with one-half normal saline at 60 milliliters per hour for three days.

Medical record review of a Nurse Practitioner's Progress Note dated December 1, 2011, revealed, "...seen for follow-up...Recent Hypernatremia and Pneumonia...has been receiving Dextrose 50% with one-half Normal Saline since November 28, 2011...thought (resident) got some pureed food with extra salt last week...Assessment: Recent Hypernatremia and volume depletion..." 

Telephone interview with Certified Nursing Assistant #2 on December 13, 2011, at 9:50 a.m., confirmed Certified Nursing Assistant #2 was on duty on November 23, 2011, and assisted resident #8 to eat supper. Certified Nursing Assistant #2 stated, "made a face when eating
Continued From page 57
the beets, but ate 100% of them, then
immediately threw up everywhere...it flew out of
(resident's) mouth and it went everywhere..."

Interview with Nurse Practitioner #1 on December 8, 2011, at 10:59 a.m., in the dining room
confirmed resident #8 was a brittle Diabetic.
"This resident was already fragile and this amount
of salt placed (resident) in a life-threatening
position; the resident became volume depleted
because of the vomiting; was not eating; became
hypernatremic and hypoglycemic."

Resident #9 was admitted to the facility on April 16, 2011, with diagnoses including Dysphagia
and Hypertension.

Medical record review of a Minimum Data Set
dated November 22, 2011, revealed a cognition
score of zero (on a scale of 0 to 15, with 15 being
the highest). Continued review revealed the
resident required supervision with meals.

Medical record review of the Physician's
Recapitulation Orders dated November 1,
through November 30, 2011, revealed, "...Pureed
diet..."

Medical record review of the Monthly Meal Intake
report revealed, "...November 23, 2011...Dinner:
75%..."

Medical record review of a nurse's note dated
November 23, 2011, at 8:30 p.m., revealed the
resident experienced nausea with vomiting and
diarrhea after eating supper and the family was
notified. At 9:30 p.m., the physician was notified
with orders for a "BMP on Friday (November 25,
## Statement of Deficiencies and Plan of Correction

**A. Building Provider/Supplier/CLIA Identification Number:** 445181

**B. Wing:**

<table>
<thead>
<tr>
<th>(X) ID Prefix Tag</th>
<th>(X) ID Prefix Tag</th>
<th>(X) Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 309</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**C. Name of Provider or Supplier:**

**Colonial Hills Nursing Center**

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

2034 Cochrane Rd

**Maryville, TN 37803**

### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID Prefix 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 309</td>
<td>Continued From page 58 2011), and push fluids for 24 hours.&quot; Medical record review of the lab results revealed the BMP was obtained on November 25, 2011, as ordered and revealed the following elevated values: BUN: 28 Sodium: 146 Chloride: 109 Resident #10 was admitted to the facility on April 24, 2010, with diagnoses including Failure to Thrive-Adult, Alzheimer's Disease, Dementia, and Dysphagia. Medical record review of a Minimum Data Set dated October 11, 2011, revealed the resident had short and long-term memory problems with severely impaired cognition skills for daily decision making. Continued review revealed the resident required extensive assistance from staff with eating meals. Medical record review of the Physician's Recapitulation Orders dated November 1, through November 30, 2011, revealed, &quot;...Pureed diet with thin liquids...&quot; Medical record review of the Monthly Meal Intake report revealed, &quot;...November 23, 2011...Dinner: 50%...&quot; Continued review revealed, &quot;Ate 2 (two) bites of beets&quot; handwritten on the bottom of the report. Medical record review of a nurse's note dated November 23, 2011, at 5:55 p.m., revealed the resident vomited twice after eating supper. At 9:30 p.m., the physician was notified with orders</td>
</tr>
<tr>
<td>F 309</td>
<td>Continued From page 59 for a &quot;BMP on Friday (November 25, 2011), and push fluids for 24 hours.” At 10:10 p.m., the family was notified. Medical record review of the lab results revealed the BMP was obtained on November 25, 2011, as ordered and revealed the following elevated lab values: BUN: 26 Chloride: 111 Resident #11 was admitted to the facility on May 12, 2011, with diagnoses including Pneumonia, Dysphagia, and Hypertension. Medical record review of a Minimum Data Set dated November 8, 2011, revealed the resident had short and long-term memory problems with severely impaired cognition skills for daily decision making. Continued review revealed the resident required extensive assistance from staff with eating meals. Medical record review of the Physician's Recapitulation Orders dated November 1, through November 30, 2011, revealed, &quot;...Pureed diet with honey-thick liquids...&quot; Medical record review of the Monthly Meal Intake report revealed, &quot;...November 23, 2011...Dinner: 100%...&quot; Medical record review of a nurse's note dated November 23, 2011, at 7:30 p.m., revealed the resident vomited twice after eating supper. At 9:20 p.m., the family was notified and at 9:30 p.m., the physician was notified with orders for a &quot;BMP on Friday (November 25, 2011), and push fluids for 24 hours.&quot;</td>
</tr>
<tr>
<td>(X4) ID PREFIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
</tr>
<tr>
<td>-------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>F 309</td>
<td>Continued From page 60 fluids for 24 hours.</td>
</tr>
<tr>
<td></td>
<td>Medical record review of lab results revealed the BMP was obtained on November 25, 2011, as ordered and revealed the following elevated lab values: BUN: 26氯化物: 108</td>
</tr>
<tr>
<td></td>
<td>Resident #12 was admitted to the facility on April 12, 2001, and readmitted on July 18, 2001, with diagnoses including Dysphagia and Dementia.</td>
</tr>
<tr>
<td></td>
<td>Medical record review of a Minimum Data Set dated September 20, 2011, revealed the resident had short and long-term memory problems with severely impaired cognition skills for daily decision making. Continued review revealed the resident was totally dependent with eating and had to be fed by staff.</td>
</tr>
<tr>
<td></td>
<td>Medical record review of the Physician's Recapitulation Orders dated November 1, through November 30, 2011, revealed, &quot;...Pureed diet with thin liquids...&quot;</td>
</tr>
<tr>
<td></td>
<td>Medical record review of the Monthly Meal Intake report revealed, &quot;...November 23, 2011...Dinner: 25% ...&quot; Continued review revealed, &quot;Ate 3 (three) bites of beets&quot; handwritten on the bottom of the report.</td>
</tr>
<tr>
<td></td>
<td>Medical record review of a nurse's note dated November 23, 2011, at 8:00 p.m., revealed the resident vomited with diarrhea after eating supper and the family was notified. At 9:30 p.m., the physician was notified with orders for a &quot;BMP on Friday (November 25, 2011), and push fluids for...&quot;</td>
</tr>
<tr>
<td>(X4) ID PREFIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>F 309</td>
<td>Continued From page 61 24 hours.&quot; Medical record review of lab results revealed the BMP was obtained on November 25, 2011, as ordered and revealed the following elevated lab values: BUN: 27 Sodium: 154 Chloride: 120 Medical record review of the nurse’s notes revealed the nurse practitioner was notified of the lab results obtained on November 25, 2011, at 4:00 p.m., and ordered to &quot;give four-ounces of fluids every two hours while awake for 48 hours.&quot; Medical record review revealed no documentation of the resident's fluid intake (to monitor the &quot;four-ounces of fluids every two hours while awake for 48 hours&quot; as ordered by the physician). Medical record review of a Nurse Practitioner Progress Note dated November 28, 2011, (no time) revealed, &quot;...Seen due to history of vomiting, illness after got food with too much salt added...&quot; Interview with the Registered Dietician on December 7, 2011, at 2:55 p.m., in the dining room confirmed, salt was put in the thickener bin on November 22, 2011, and on November 23, 2011, Cook #1 used salt instead of thickener in the pureed beets. The Registered Dietician stated, &quot;I instructed dietary staff to empty the salt and thickener bins, wash, label, and refill them with the correct substances.&quot; The Registered Dietician confirmed, &quot;Salt and thickener do not look alike.&quot;</td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

**COLONIAL HILLS NURSING CENTER**

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

**2034 COCHRAN RD**

**MARYVILLE, TN 37803**

**DATE SURVEY COMPLETED**

**12/15/2011**
Interview with the Assistant Dietary Manager on December 7, 2011, at 3:45 p.m., in the dining room confirmed on November 23, 2011, when the pureed beets were prepared, twelve pounds of beets (approximately 65 four-ounce servings) were pureed with approximately twenty-five pounds of salt (minus approximately one cup of salt unused and remaining in the bin).

Telephone interview on December 12, 2011, with the Administrator of record on November 23, 2011, stated, "I called the Medical Director on November 23, 2011 around 9:30 p.m., to report the incident of the salt used as thickener in the beets for dinner; (Medical Director) said to control any adverse affects from the salt, to control the vomiting and push fluids, to get a BMP on Friday to evaluate the sodium," and that "Dr. (Medical Director's name) was concerned the sodium levels would be elevated from too much salt and residents may need intravenous fluids and residents would have potential issues."

Continued interview confirmed, "I notified the 3:00 p.m. - 11:00 p.m. Registered Nurse Supervisor and gave the (blanket) orders."

Interview with Registered Nurse #4 on December 8, 2011, at 6:00 p.m., in the dining room confirmed on November 23, 2011, during supper, residents were not eating their beets and became aware the beets were too salty. "Resident #6 had projectile vomiting...the ED (Administrator, also known as the Executive Director) called me, explained to have talked with the (Medical Director) and the ED gave me orders, that (Medical Director) wanted anyone vomiting after supper to push fluids for the next 24 hours and a BMP on Friday; and to consider this an incident."
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 309</td>
<td>Continued From page 63 When Registered Nurse #4 was asked by the surveyor if the ED was a licensed nurse or physician, the RN stated, &quot;No, the ED's not a nurse or doctor.&quot; Interview with the Medical Director on December 8, 2011, at 1:37 p.m., in the dining room revealed the Medical Director received two calls from the facility on November 24, 2011, and was informed a large amount of salt had mistakenly been used for thickener in pureed beets. On the first call, it was reported that two to three residents experienced nausea and vomiting; (blanket) orders were to hydrate, treat the symptoms, and blood work the next morning. On the second call, more residents were experiencing nausea and vomiting; (blanket) orders were reaffirmed - hydration management and treatment of symptoms. Continued interview confirmed the Medical Director had not reviewed the facility's investigation of the salted beets incident on November 23, 2011, and stated &quot;I was assured it was done.&quot; The Medical Director stated was also a Medical Director at another nursing home in the area and stated &quot;The other facility where I'm Medical Director has good communication, but that's not the case here.&quot; The Medical Director stated, &quot;On average, it is recommended the healthy adult may consume three to four grams of salt per day.&quot; Further interview confirmed, &quot;An unhealthy or fragile resident having consumed the unintended salted beets will be affected more adversely versus a healthy individual...The extra salt did place resident #6 at a greater likelihood for an adverse reaction secondary to the resident's already debilitated condition.&quot; Interview with the Registered Dietician on</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 309</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID</td>
<td>PREFIX</td>
<td>TAG</td>
<td>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
<td>COMPLETION DATE</td>
</tr>
<tr>
<td>----</td>
<td>--------</td>
<td>------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>F 309</td>
<td>Continued From page 64</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 309</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

December 13, 2011, at 1:47 p.m., in the dining room, confirmed on November 23, 2011, each serving of pureed beets was approximately a four-ounce serving in size. Continued interview confirmed each four-ounce serving contained six grams of salt, which was at least 2 grams more in one serving, than is recommended for the healthy average adult in one day.

Interview with the Interim Administrator/Director of Nursing on December 15, 2011, at 10:50 a.m., in the Conference Room, confirmed resident #6 returned from the hospital from an inpatient stay dating November 24, 2011 through December 9, 2011, after eating 100% of salted beets provided to the resident by the facility on November 23, 2011, resulting in extreme nausea and vomiting. The resident aspirated and was diagnosed with Hypernatremia, Aspiration Pneumonia, and Acute Kidney Injury, and was readmitted to the nursing home on December 9, 2011, on comfort measures due to a decline from the Aspiration Pneumonia. The Interim Administrator/Director of Nursing confirmed the facility failed to prepare and serve resident food according to menu, by adding salt instead of thickener, to pureed beets on November 23, 2011.

To summarize, on November 22, 2011, the facility failed to place table salt in the correct bin. On November 23, 2011, pureed beets were prepared with table salt instead of thickener and seven residents consuming the pureed beets (during the dinner meal) experienced nausea and vomiting. The Administrator was notified on November 23, 2011, and called the Medical Director at approximately 9:30 p.m. to 9:50 p.m.; no licensed nurse spoke to the Medical Director. The Medical
A. BUILDING PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID 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>
</tr>
</thead>
</table>
| F 309 | Continued From page 65
Director gave a blanket order to the Administrator for residents that consumed the salted pureed beets and were symptomatic (nausea and vomiting) to treat the nausea and vomiting; hydrate (push fluids); and get a BMP..." The Administrator then notified the 3:00 p.m.-11:00 p.m., RN Supervisor, and gave the blanket order; the RN Supervisor took an order lab work and treatments from an unauthorized individual.  The facility's failure to ensure the thickener bin was correctly labeled and failure to follow the recipe to thicken pureed beets placed seven residents in Immediate Jeopardy.

Review of a facility timeline (no date) revealed the Assistant informed the Manager the bins had been corrected.  At 6:45 p.m.-6:50 p.m., the Administrator, Registered Dietician, Director of Nursing, Regional Director of Clinical Services and Medical Director were notified.  Instructions were given and added to the 24-hour report on all nursing units that all residents receiving pureed beets should be observed for nausea and vomiting and these symptoms were to be reported to the physician. At 9:00 p.m., families were notified of the vomiting. On November 24, 2011, the Registered Dietician entered the kitchen and verified the thickener bin had been cleaned and labeled; and that both bins were in different locations in the storage areas. Bin labels were identified and items (salt and thickener) were tasted to verify one was salt and one was thickener. The Registered Dietician verified with Cook #1 that thickener was not used in food on November 23, 2011, for breakfast and lunch items. The Registered Dietician began in-servicing dietary staff on Food Safety; Food Seasoning; Food Tasting; Following Recipes; and... |
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID 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>
</tr>
</thead>
</table>
| F 309        | Continued From page 66  
Labeling/Dating Containers. The Registered Dietician observed the lunch tray line to ensure all trays were done properly. On November 28, 2011, at 1:00 p.m., the administrator went with the Dietary Manager to observe the labeling and separate bins for the thickener and salt. The Assistant Dietary Manager emptied and cleaned the thickener bin and put new thickener in the bin. At 7:00 p.m., an emergency Quality Assurance Committee Meeting was held; the incident, interventions, and training implemented was discussed and approved by the Committee.  

In summary, corrective actions were received and were validated by the survey team through review of documents, staff interviews, and observations conducted onsite on December 7, 2011, through December 15, 2011. The survey team verified the corrective actions by:  
1.Reviewing the facility's plan for ensuring the salt and thickener bins are clearly labeled and are separately located from one another.  
2.Reviewing the facility's plan for auditing the food to ensure dietary staff is following the plan.  
3.Reviewing the facility's inservice records to ensure all dietary staff have been educated regarding the changes to and implementation of food safety, food seasoning, following recipes, labeling and dating containers, bulk purchasing, and tasting food.  
The Dietary Manager on staff at the time of the occurrence and at the beginning of the survey resigned on December 12, 2011, and an interim Dietary Manager had been appointed on December 12, 2011.  
4.Conducting interviews with 9 of 20 dietary staff employed to determine the level of comprehension gained through in-service | F 309 | F 309 | 12/15/2011 |
## Statement of Deficiencies and Plan of Correction

**NAME OF PROVIDER OR SUPPLIER**

**COLONIAL HILLS NURSING CENTER**

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

2034 COCHRAN RD  
MARYVILLE, TN 37803

### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID 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>
</tr>
</thead>
</table>
| F 309         | Continued From page 67  
education conducted regarding changes to the facility policy for food safety, food seasoning, following recipes, labeling and dating containers, bulk purchasing, and tasting food.  
5. Observing pineapple juice thickened by dietary staff according to recipe. Observing the availability of purchased, pre-thickened liquids.  
Non-compliance continues at an "E" level for monitoring corrective actions.  
C/O #28971 | F 309 |  |  |
| F 354         | 483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON  
Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.  
Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.  
The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.  
This REQUIREMENT is not met as evidenced by:  
Based on review of the BENHA (Board of Examiners for Nursing Home Administrators) Information provided by the facility and interview, | F 354 | |  |

**Event ID:** WSHQ11  
**Facility ID:** TN0502  
**If continuation sheet Page:** 68 of 80
**Summary Statement of Deficiencies**

- **F 354**
  - Continued From page 68
  - The facility failed to ensure a Registered Nurse serves as the Director of Nursing on a full time basis.

  The findings included:

  - Review of the BENHA information and interview on December 8, 2011, at 10:50 a.m., in the dining room (room inside the dining room with double doors) with the Regional Vice President confirmed the Director of Nursing (DON) was serving as the Administrator of the facility for "thirty days."

  - Interview on December 15, 2011, at 10:45 a.m., in the conference room, with the DON confirmed the DON was filling both roles as the Administrator and the DON. The DON had served both roles for one week, December 8 through December 15, 2011.

- **F 367**
  - 483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN
  - Therapeutic diets must be prescribed by the attending physician.

  This REQUIREMENT is not met as evidenced by:
  - Based on medical record review, review of hospital medical records, review of facility investigation records, review of facility policy, and interview, the facility failed to prepare and serve a therapeutic diet according to physician orders and food recipe, for seven residents (#6, #7, #8, #9, #10, #11, #12) of fifteen residents reviewed. The

---

**Provider's Plan of Correction**

- **F 354**
  - **ID**
  - **Prefix**
  - **Tag**

- **F 367**
  - **ID**
  - **Prefix**
  - **Tag**
## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**A. BUILDING PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>445181</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**B. WING _____________________________**

**NAME OF PROVIDER OR SUPPLIER**

**COLONIAL HILLS NURSING CENTER**

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

| 2034 COCHRAN RD  |
| MARYVILLE, TN 37803 |

**STATEMENT OF DEFICIENCIES**

**(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)**

<table>
<thead>
<tr>
<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>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 367</td>
<td></td>
<td></td>
<td>Continued From page 69 facility's failure placed residents #6, #7, #8, #9, #10, #11, #12 in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment or death).</td>
<td></td>
</tr>
</tbody>
</table>

A meeting was held on December 15, 2011, at 4:45 p.m., in the Conference Room, with the Director of Nursing/Interim Administrator, Regional Director of Clinical Services, Corporate Director of Clinical Services, Regional Vice President, and Divisional Vice President to inform the facility of the Immediate Jeopardy. The Immediate Jeopardy was effective November 23, 2011.

Observation, review of in-service records, and interviews revealed the facility took corrective measures which removed the Jeopardy effective December 6, 2011. The deficient practice continues at an "E" level until all corrections have been monitored and evaluated for effectiveness.

The findings included:

Review of a facility invoice from a food vendor dated November 22, 2011, revealed one twenty-five pound bag of granulated, plain salt was delivered to the facility.

Review of the facility Dinner Menu dated November 23, 2011; revealed pureed beets were on the menu.

Review of a food vendor recipe "Pickled Beets PU (puree)" dated November 29, 2011, at 8:31:40 a.m., revealed, "...Yield: 65 portions...Portions:
<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>
</tr>
</thead>
<tbody>
<tr>
<td>F 367</td>
<td>Continued From page 70</td>
<td></td>
</tr>
<tr>
<td>65...Ingredients and Instructions...Pickled beets - 65 ½ (sixty-five and one-half) cup...Food thickener - 1 ¼ (one and one-fourth) Cup 2 Tablespoon (one and one-fourth cup, plus one tablespoon). &quot;Recipe instructions provided to dietary prior to November 23, 2011,&quot; handwritten below the instructions of the recipe.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review of a facility policy &quot;Food Preparation&quot; dated as last revised: January 1, 2007, revealed, &quot;...Guidelines: Menu items are prepared according to the menu, production sheets and recipes...&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interview with the Registered Dietician on December 13, 2011, at 1:47 p.m., in the dining room, confirmed on November 23, 2011, each serving of pureed beets was approximately a four-ounce serving in size. Continued interview confirmed each four-ounce serving contained six grams of salt, which was at least 2 grams more in one serving, than is recommended for the healthy average adult in one day.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refer to F-309 (K)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C/O #28971</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<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>
</tr>
</thead>
<tbody>
<tr>
<td>F 490</td>
<td>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</td>
<td></td>
</tr>
<tr>
<td>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID PREFIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>ID PREFIX TAG</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>F 490</td>
<td>Continued From page 71</td>
<td>F 490</td>
</tr>
</tbody>
</table>

This REQUIREMENT is not met as evidenced by:

Based on medical record review, review of the facility investigation, review of facility policy and interview, the facility failed to be administered in a manner to protect two residents (#1 and #2) from sexual assault; to immediately remove the male alleged perpetrator from the facility and prevent his unsupervised return; to ensure policies were followed for investigation and reporting of the sexual assaults; and to ensure residents were protected from further sexual assaults of four residents reviewed who were at risk for sexual assault.

The facility's failure has caused sexual abuse of two residents (#1 and #2) and has placed other residents at risk for sexual assault.

The facility's failure placed all female residents in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident).

Based on medical record review, review of hospital medical records, review of facility investigation records, review of facility policy, review of a vendor invoice, and interview, the facility failed to be administered in a manner to ensure food ingredients were stored in correct containers; failed to ensure licensed nurses received orders from the licensed physician; and failed to prepare and serve resident food.
### Summary Statement of Deficiencies

**F 490** Continued From page 72

According to menu, by adding approximately twenty-five pounds of salt to twelve pounds of pureed beets. Seven residents (#6, #7, #8, #9, #10, #11, #12) of fifteen residents reviewed ate the salted beets and suffered a negative outcome.

The Regional Vice President, the Regional Director of Clinical Services and the Director of Nursing were informed of the Immediate Jeopardy in the Administrator's office on December 5, 2011, at 12:15 p.m. The Immediate Jeopardy was effective November 26, 2011, and is ongoing. A partial extended survey was conducted on December 15, 2011.

The findings included:

Interview in the office on December 5, 2011, at 10:30 a.m., with the Regional Vice President (RVP), the Regional Director of Clinical Services (RDCS) and the Director of Nursing (DON) revealed the former Administrator resigned on November 29, 2011. Continued interview with the RVP, the RDCS and the DON confirmed resident #1 and resident #2 were sexually assaulted on Saturday, November 26, 2011, "around" 6:00 p.m. Continued interview with the RVP, the RDCS and the DON confirmed resident #1 was sexually assaulted and removed from the café area, other female residents were left at the table with the male alleged perpetrator and placed at risk for sexual assault. Continued interview with the RVP, the RDCS and the DON confirmed resident #2 was sexually assaulted after resident #1 was sexually assaulted and removed from the area. Continued interview with the RVP, the RDCS and the DON confirmed the...
**SUMMARY STATEMENT OF DEFICIENCIES**

Each deficiency must be preceded by full regulatory or LSC identifying information.

<table>
<thead>
<tr>
<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>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 490</td>
<td>Continued From page 73 male alleged perpetrator was not removed from the facility after sexually assaulting residents #1 and #2 and confirmed the male alleged perpetrator returned to the facility on Sunday, November 27, 2011. Continued interview with the RVP, the RDCCS and the DON confirmed the male alleged perpetrator returned to the facility on Monday, November 28, 2011; however the RVP, the RDCCS and the DON denied being informed the alleged perpetrator had entered the room of resident #2 on Monday, November 28, 2011. Continued interview with the RVP, the RDCCS and the DON confirmed the Administrator, the ADON (Assistant Director of Nursing) and the RN (Registered Nurse) Weekend Supervisor (RN #1) were informed of the sexual assault on Saturday, November 26, 2011, but the Administrator, the ADON and RN #1 all failed to initiate an investigation of the assaults. Continued interview with the RVP, the RDCCS and the DON confirmed the Administrator failed to notify Law Enforcement and the State agency within twenty-four hours of the sexual assault as required by Federal regulations, facility policy and the Elder Justice Act. Continued interview with the RVP confirmed the Administrator failed to notify the RVP of the assaults on November 26, 2011, and if the Administrator had notified the RVP, the RVP &quot;could have walked (Administrator) through the process.&quot; Continued interview with the RVP and the RDCCS confirmed the RDCCS, the corporate office, and the RVP were not notified of the sexual assaults until Monday, November 28, 2011, in the &quot;afternoon.&quot; Continued interview with the DON confirmed the DON was not notified of the sexual assaults on November 26, 2011, and had no knowledge of the assaults until the former Administrator called the DON at home &quot;late in the</td>
<td>F 490</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ID</td>
<td>TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES</td>
<td>ID</td>
<td>TAG</td>
</tr>
<tr>
<td>----</td>
<td>-----</td>
<td>----------------------------------</td>
<td>----</td>
<td>-----</td>
</tr>
<tr>
<td>F 490</td>
<td>Continued From page 74</td>
<td>afternoon&quot; on Monday, November 28, 2011, and began inservicing the DON on abuse. The DON asked the former Administrator if something had happened, and was then informed of the sexual assaults.</td>
<td>F 490</td>
<td></td>
</tr>
</tbody>
</table>

Interview on December 5, 2011, from 1:30 p.m. -2:30 p.m. in the office, with the Director of Social Services (DSS) confirmed the DSS "first learned" of the sexual assaults of residents #1 and #2 on Monday, November 28, 2011. The DSS reported the former Administrator gave the DSS written statements (interviews with resident #1 and #2 on November 26, 2011 by RN #1) and asked the DSS to follow up. The DSS interviewed both residents. Continued interview with the DSS revealed the DSS went to the former Administrator on November 28, 2011, "around 11:30 a.m., to 12:30 p.m., and informed the Administrator, "We have a problem. We need to call the police" and reported to the Administrator the two residents had been sexually assaulted. Continued interview with the DSS revealed the Administrator told the DSS, "Don't start throwing the word sexual assault around. Don't get over excited." Continued interview with the DSS confirmed the Administrator "was not responding." The DSS informed the RDCS of the sexual assault. The RDCS informed the corporate office and was directed to notify Law Enforcement. Continued interview with the DSS revealed, "I was very pleased Corporate took this seriously. (Administrator) did not take it seriously. Telephone interview on December 5, 2011, at 5:00 p.m., with the former Administrator (Administrator at the time of the sexual assaults) confirmed the Administrator was notified on
### Statement of Deficiencies and Plan of Correction

**DATE SURVEY COMPLETED**: 12/15/2011

**State**: Tennessee

**Facility Name**: Colonial Hills Nursing Center

**Address**: 2034 Cochran Rd, Maryville, TN 37803

**Provider/Supplier/CLIA Identification Number**: 445181

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 490</td>
<td></td>
<td></td>
<td>Continued From page 75</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Saturday, November 26, 2011, at 6:20 p.m., by the ADON that resident #5's son had touched the arm and leg of two residents. Continued interview with the former Administrator confirmed the ADON informed the Administrator the male alleged perpetrator was &quot;intoxicated&quot; and making residents nervous. Continued interview with the former Administrator confirmed the Administrator did not direct the ADON to escort the male alleged perpetrator from the facility and did not direct the ADON to notify Law Enforcement of the sexual assaults. Telephone interview on December 5, 2011, at 5:20 p.m., with the ADON confirmed CNA (Certified Nursing Assistant) #1 informed the ADON on Saturday, November 26, 2011, at 6:00 p.m., that resident #5's son had touched the leg of resident #1; the resident was uncomfortable; and CNA #1 had removed the resident from the café area. Continued interview with the ADON confirmed resident #2 was sexually assaulted after resident #1 was removed from the area and confirmed the male alleged perpetrator was left in the café area with three other residents after he assaulted resident #1. The ADON confirmed, &quot;There was a lag time when transported (resident #1) and when (resident #2) was assaulted.&quot; Continued interview with the ADON revealed the ADON directed RN #1 to interview both residents, and &quot;That was the last I heard of it.&quot; Continued interview with the ADON confirmed the ADON notified the Administrator of the sexual assaults on November 26, 2011, and was directed by the Administrator to not complete an Incident report or notify Law Enforcement, the DON or the corporate office.</td>
<td></td>
</tr>
</tbody>
</table>
## Statement of Deficiencies and Plan of Correction

### Name of Provider or Supplier

**Colonial Hills Nursing Center**

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

2034 Cochran Rd
Maryville, TN 37803

### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>ID 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>
</tr>
</thead>
<tbody>
<tr>
<td>F 490</td>
<td>Continued From page 76 Interview with the Registered Dietician on December 7, 2011, at 2:55 p.m., in the dining room confirmed, salt was put in the thickener bin on November 22, 2011, and on November 23, 2011, Cook #1 used salt instead of thickener in the pureed beets. Interview with Cook #1 on December 7, 2011, at 4:35 p.m., in the dining room confirmed Cook #1 used salt to thicken the pureed beets for dinner on November 23, 2011. &quot;I know the difference between salt and thickener, but when I pureed and thickened the beets, I didn't follow the recipe, and I didn't pay attention to the actual substance in the thickener bin...As long as I've worked here the thickener bin has never been labeled...I did not realize I had thickened the beets with salt until the residents became sick after eating supper (dinner).&quot; Telephone interview on December 12, 2011, with the Administrator of record on November 23, 2011, stated, &quot;I called the Medical Director on November 23, 2011 around 9:30 p.m., to report the incident of the salt used as thickener in the beets for dinner; (Medical Director) said to control any adverse affects from the salt, to control the vomiting and push fluids, to get a BMP on Friday to evaluate the sodium,&quot; and that &quot;Dr. (Medical Director's name) was concerned the sodium levels would be elevated from too much salt and residents may need intravenous fluids and residents would have potential issues.&quot; Continued interview confirmed, &quot;I notified the 3:00 p.m.-11:00 p.m. Registered Nurse Supervisor and gave the orders.&quot; Interview with Registered Nurse #4 on December</td>
<td>F 490</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Event ID:** WSHQ11  
**Facility ID:** TN0502  
**If continuation sheet Page:** 77 of 80
<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 490</td>
<td>Continued From page 77</td>
<td></td>
</tr>
</tbody>
</table>
|        | 8, 2011, at 6:00 p.m., in the dining room confirmed on November 23, 2011, during supper, residents were not eating their beets and became aware the beets were too salty. "Resident #6 had projectile vomiting...the ED (Administrator, also known as the Executive Director) called me, explained to have talked with the (Medical Director) and the ED gave me orders, that (Medical Director) wanted anyone vomiting after supper to push fluids for the next 24 hours and a BMP on Friday; and to consider this an incident." When Registered Nurse #4 was asked by the surveyor if the ED was a licensed nurse or physician, the RN stated, "No, the ED's not a nurse or doctor."

The facility's failure resulted in critical sodium and chloride levels for two residents (#6, #7), requiring hospital treatment; resulted in elevated sodium and chloride levels for resident #8, requiring intravenous fluids; and resulted in elevated sodium and chloride levels for residents #9, #10, #11, #12, requiring increased oral "pushed" fluids. The facility's failure placed residents #6, #7, #8, #9, #10, #11, #12 in Immediate Jeopardy.

Refer to F157
Refer to F223 Substandard Quality of Care
Refer to F225 Substandard Quality of Care
Refer to F281
Refer to F309 Substandard Quality od Care
Refer to F354
Refer to F367

C/O #28971

F 497 483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE
### Summary Statement of Deficiencies

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 inservice records and interview, the facility failed to ensure Certified Nursing Assistants (CNA) received the required twelve hours of inservice training per year.

The findings included:

Review of inservice records provided by the Staff Development Coordinator (SDC) on December 13, 2011, revealed the facility was not tracking CNA inservice hours to ensure each CNA received the required twelve hours of inservice training in the past twelve months.

Interview on December 13, 2011, at 11:30 a.m., in the dining room (an enclosed room in the dining room with double doors) with the SDC confirmed the facility had no system in place to track the inservice hours for CNAs.

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>ID 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>
</tr>
</thead>
<tbody>
<tr>
<td>F 497 Continued From page 78</td>
<td>F 497</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The facility must continue tracking CNAs' inservice hours with a system that can be audited to ensure compliance with the 12-hour requirement.
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Colonial Hills Nursing Center  
**Street Address, City, State, Zip Code:** 2034 Cochran Rd, Maryville, TN 37803

<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>
</table>
| F 497 | | | Continued From page 79  
Interview with the SDC confirmed the SDC had knowledge that some of the CNAs "were bad" about not attending mandatory inservice training and knew that some CNAs had not had the required number of hours (unable to give specific counts or identification of CNAs). Continued interview with the SDC confirmed the SDC "got no support" from the former Administrator in requiring staff to attend. Continued interview with the SDC confirmed the former Administrator would not allow the SDC to "enforce" attendance at mandatory inservices.  
Interview on December 13, 2011, at 2:10 p.m., in the dining room, with the Regional Vice President (RVP) confirmed the SDC was "not able to keep up with inservices or hours." Continued interview with the RVP confirmed the RVP had knowledge the SDC received no support from the former Administrator and confirmed the RVP had knowledge the facility had no system in place to track inservice attendance hours for CNAs.  
C/O #28971 | F 497 | | | | | | |