<table>
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<tr>
<th>(X1) PROVIDER/SUPPLIER/CLA ID</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<tr>
<td>445318</td>
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<td>06/07/2012</td>
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NAME OF PROVIDER OR SUPPLIER: CHRISTIAN CARE CENTER OF CHEATHAM COUNTY, INC

STREET ADDRESS, CITY, STATE, ZIP CODE: 2691 RIVER ROAD, ASHLAND CITY, TN 37016

(X3) ID PREFIX TAG: F 225

SUMMARY STATEMENT OF DEFICIENCIES:

<table>
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<tr>
<th>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</th>
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<tr>
<td>483.13(c)(1)(8)-(9), (c)(2) - (4)</td>
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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 appropriate corrective action must be taken.

Preparation and/or execution of this plan of correction does not constitute an admission or acquiescence by Christian Care Center of Cheatham County of the truth of the facts alleged or conclusions set forth in this statement of deficiencies.

Christian Care Center of Cheatham County believes this plan of correction solely because it is required to do so for continued state, federal, and Medicaid program participation.

This facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal, and any other applicable legal or administrative proceedings.

This plan of correction should not be taken as establishing any standard of care and the facility submits the actions taken by it in response to the survey findings for evidence of the standard of care.

F 225 Christian Care Center of Cheatham County believes current practices were in compliance with the applicable standard of care, but that in order to respond to this citation from the surveyors, the facility is taking the following additional actions:

**Correction Action for Tarred Residents:**

- On 3-31-12, a concern was voiced regarding an allegation of abuse. An investigation was initiated in accordance with facility policy, to review an allegation of abuse regarding resident 827. The investigation was completed with resident, staff, family, and physician interviews. A summary of findings concluded that the allegation was not substantiated. On 4-2-12, the interdisciplinary team was informed of the allegation and the medical record was updated to reflect the resident's condition. On 5-6-12, the facility administrator reviewed the investigation with the state survey team.

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTED SIGNATURE: [Signature]

DATE: 6-19-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patient. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 60 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued program participation.
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This REQUIREMENT is not met as evidenced by:
Based on review of State of Tennessee regulations, policy review, medical record review, and interview, it was determined the facility failed to report an alleged allegation of abuse to the State agency for 1 of 3 (Resident #29) alleged occurrences of abuse reviewed.

The findings included:

Review of State of Tennessee regulations Chapter 1200-08-06-11(2) documented, "Unusual events shall be reported by the facility to the Department of Health in a formal designed by the Department within seven (7) business days of the date of the identification of the abuse of a patient or an unexpected occurrence or accident that results in death, life threatening or serious injury to a patient."

Review of the facility's "Abuse Protocol-Tennessee Facilities" policy documented, "...The administrator will notify the following of any/all such reports: 1. The appropriate State Health Department office of Licensing and Regulation office in accordance with specific state regulations and time frames. Note: Results of the investigation will be reported within five (5) working days in accordance with State law to the State Survey and Certification Agency...D. Should an investigation result in conclusions that false allegations were made the investigation will immediately cease and all appropriate agencies will be notified...

Medical record review for Resident #29

F 226 Identification of other residents with potential to be affected:

On 6/13/13, the administrator reviewed with the Director of Social Services all current reported grievances/concerns. It was determined that there were no other reports/allegations of abuse at the time.

Systematic Changes:

On 6/13/13, the administrator reviewed the Abuse Policy with the facility management team and re-emphasized the reporting aspect of the policy. The administrator also met with the designated person in case of the absence of the administrator the procedure of how to report any allegation to the state. On 6/20/13, the facility will hold a staff in service for the other facility staff to review the Abuse Policy and continue to in-service the staff at least quarterly.

Monitoring:

Any concerns/grievances will be discussed during daily management meetings that are held Monday-Friday. On the weekends, the charge nurses are responsible for contacting the administrator or designee of any abuse allegation so that the investigation can be initiated immediately. Any concern regarding abuse will also be discussed and reviewed during our monthly Performance Improvement Committee meeting. Members of that committee include the administrator, medical director, Director of Nursing, the Director of Social Services, Medical Records, Maintenance Supervisor, Activities Director, Business Office Manager, Human Resources, Dietary Manager and Assistant Director of Nursing.

As part of our ongoing QIS, interviews, all residents will be interviewed and assessed quarterly for any signs/symptoms/complaint of abuse. The result of these interviews will be given to the Director of nursing and presented to the Performance Improvement Committee on a monthly basis. Any indicator/allegation of abuse will be investigated immediately and reported to the state within 5 working days.
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<thead>
<tr>
<th>ID</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>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLIANCE DATE</th>
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| F 225 | | Continued From page 2 documented an admission date of 1/31/05 with diagnoses of Weakness, Congestive Heart Failure, Anemia, Dementia with Delusions, Psychosis, Depressive Disorder and Lack of Coordination. Review of the facility's "Resident Abuse Investigation Report" for Resident #29 documented, "...Resident has bruised areas on right hand and left hand... date reported 3/31/12."
During a telephone interview conducted in the conference room on 6/4/12 at 4:30 PM, Resident #29's family member stated, "Did have an incident first of the year she [Resident #29] told us a staff member twisted her arm, she did have bruises, the nurses were told, they did question mother with me present, they never could prove anything..."
During a interview in the conference room on 6/5/12 at 3:15 PM, the Administrator was asked about the allegation of abuse to Resident #29. The Administrator stated, "Yes, did have an allegation earlier in year, have that investigation, did not report it to state..."
The facility failed to report an allegation of abuse and submit the investigation to the state agency within 5 working days of the incident.

F 228 | | 483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES | | | The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
This REQUIREMENT is not met as evidenced
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by:
Based on policy review, medical record review and interview, it was determined the facility failed to implement the facility's policy for reporting alleged allegations of abuse to the State agency for 1 of 3 (Resident #28) alleged occurrences of abuse reviewed.

The findings included:

Review of the facility's "Abuse Protocol-Tennessee Facilities" policy documented, "The administrator will notify the following of any/all such reports: 1. The appropriate State Health Department office of Licensing and Regulation office in accordance with specific state regulations and time frames. Note: Results of the investigation will be reported within five (5) working days in accordance with State law to the State Survey and Certification Agency. D. Should an investigation result in conclusions that false allegations were made the investigation will immediately cease and all appropriate agencies will be notified."

Medical record review for Resident #28 documented an admission date of 1/31/05 with diagnoses of Weakness, Congestive Heart Failure, Anemia, Dementia with Delusions, Psychosis, Depressive Disorder and Lack of Coordination. Review of the facility's "Resident Abuse Investigation Report" documented, "Resident has bruised areas on right hand and left hand... date reported 3/31/12."

During a telephone interview conducted in the conference room on 6/4/12 at 4:30 PM, Resident #28's family member stated, "Did have an
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incident first of the year she [Resident #28] told us a staff member twisted her arm, she did have bruises, the nurses were told, they did question mother with me present, they never could prove anything..."

During a interview in the conference room on 6/6/12 at 3:15 PM, the Administrator was asked about the allegation of abuse on Resident #20. The administrator stated, "Yes, did have an allegation earlier in year, have that investigation, did not report it to state..."

The facility failed to implement the abuse policy by failing to report an allegation of abuse. 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

F 279
A facility must use the results of the assessment to develop, review and revise the resident’s comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident’s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident’s exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).
This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review, observation and interview, it was determined the facility failed to develop a comprehensive care plan for restorative nursing/range of motion for 2 of 15 (Residents #46 and 71) sampled residents reviewed of the 35 residents in the Stage 2 review.

The findings included:

1. Review of the facility's "Care Plans" policy documented, ". . . the Care Plan shall reflect the following: a. PROBLEMS: Any areas of difficulty or concern that prevents the Resident from reaching his/her fullest potential...
INTERVENTIONS: The specific and realistic action or intervention the staff will take to assist the Resident in meeting/achieving the goals."

2. Medical record review for Resident #46 documented an admission date of 10/13/11 with diagnoses of Benign Epilepsy of Brain, Anxiety, Encephalopathy, Dysphagia, Epilepsy, Aphasial, Depression, Hypertension, Myasthenia Gravis and Incontinence. Review of the quarterly Minimum Data Set (MDS) dated 10/23/11 and the Significant Change Assessment (SCA) dated 6/13/12 documented, ". . . Section G Functional Limitation In Range of Motion (ROM) impairment in both sides of the upper extremities (shoulder, elbow, wrist, hand), impairment on both sides of the lower extremities (hip, knee, ankle, foot)." Review of the current care plan dated 4/19/12 did not include ROM exercises.
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Observations in the main dining room on 6/4/12 at 11:40 AM, revealed Resident #46 seated in a wheelchair with a body alarm in use and a soft lap belt restraint in use. Resident #46’s right ankle and left wrist were turned inward.

During an interview at the nurses’ station on 6/6/12 at 8:40 AM, Nurse #1 was asked if the current care plan for Resident #46 included ROM. Nurse #1 reviewed the care plan and stated, “I can’t see ROM specifically. I know the techs (certified nursing technicians) would have given ROM with care…”

During an interview in the MDS office on 6/8/12 at 8:57 AM, the MDS Coordinator was asked if the care plan for Resident #46 included ROM exercises. The MDS Coordinator reviewed the care plan and stated, “I did not care plan for ROM. She does have limitations in her upper and lower extremities, but life (ROM) not on the care plan. That’s something I need to add to the care plan.”

3. Medical record review for Resident #71 documented an admission date of 12/30/11 with diagnoses of Diastolic Heart Failure, Organic Psychotic Conditions, Senile Dementia, Dementia with Lewy Bodies, Psychosis, Osteoarthritis, Hyperlipidemia, Benign Prostatic Hypertrophy and Chronic Ischemic Heart Disease. Review of the admission MDS dated 1/20/12 and the 30 day MDS dated 2/10/12 revealed Section G for Functional Status assessed Resident #71 as not steady and only able to stabilize with human assistance when transferring from surface to surface and between bed and chair or

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Monitoring:
The Director of Nursing will monitor for compliance on a monthly basis and report findings to the Performance Improvement Committee for the next three months. Members of that committee include: the administrator, medical director, Director of Nursing, Director of Social Services, Medical Records, Maintenance Supervisor, Activities Director, Business Office Manager, Human Resources, Dietary Manager, and Assistant Director of Nursing.
The Director of Nursing and MDS Coordinator will randomly audit charts to ensure that the care plans reflect restorative services that are needed. This will be done for the next six months and results will be reported to the Performance Improvement Committee on a monthly basis.

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CHRISTIAN CARE CENTER OF CHEATHAM COUNTY, INC

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wheelchair. Review of the Physical Therapy (PT) progress notes dated 2/17/12 documented Resident #71 was discharged from therapy on 2/17/12. Resident #71 required extensive assistance to transfer and required total assistance with wheelchair mobility. PT recommended ongoing therapy with restorative nursing. Review of the Occupational Therapy (OT) progress notes dated 2/17/12 documented Resident #71 was discharged from therapy on 2/17/12. Resident #71 required support with all activities of daily living. OT recommended ongoing therapy with restorative nursing. Review of the "Restorative Nursing Documentation" for February 2012, March 2012, April 2012, May 2012 and June 2012 documented Resident #71 had received services to maintain bilateral upper extremity strength/ROM and to maintain bilateral lower extremity strength/ROM. Review of the current care plan dated 4/4/12 did not include restorative nursing or interventions to maintain upper and lower extremity strength and ROM.

Observations in the 400 hallway on 6/6/12 at 10:35 AM, revealed Resident #71 seated in a high back chair with a body alarm in use and wearing protective sleeves on both arms.

During an interview in the conference room on 6/6/12 at 2:51 PM, the Director of Nursing (DON) was asked if the current care plan for Resident #71 included restorative nursing and ROM for maintaining strength. The DON reviewed the care plan and stated, "The updates for restorative nursing should have been added to the current care plan when it was reviewed. Restorative is not on there."

RECEIVED
9/12/2012