**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<td>445282</td>
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<td>FEB 10 2012</td>
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<tr>
<th>NAME OF PROVIDER OR SUPPLIER</th>
<th>STREET ADDRESS, CITY, STATE, ZIP CODE</th>
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<tbody>
<tr>
<td>CUMBERLAND MANOR NURSING CENTER</td>
<td>4343 ASHLAND CITY HWY NASHVILLE, TN 37218</td>
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<tr>
<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F253</td>
<td>SS=E</td>
<td>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</td>
<td>F253</td>
<td></td>
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The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This **REQUIREMENT** is not met as evidenced by:

Based on policy review, observation and interview, it was determined the housekeeping services failed to maintain a clean and sanitary environment in 23 of 63 (rooms 201, 203, 205, 301, 304, 305, 306, 310, 501, 502, 503, 506, 508, 509, 510, 601, 607, 609, 705, 706, 710, 711 and 712) resident rooms and soiled shower chairs, equipment, curtains and floors in 2 of 2 (Central Bath 1 and 2) central baths.

The findings included:

1. Review of the facility's "Routine Cleaning of Equipment" policy documented, "...Wheelchairs, geri-chairs, walkers, scooters, merry-walkers, canes and other mobility aids should be cleaned weekly by the night shift..." IV [intravenous] poles, feeding pumps and med carts should be kept clean at all times by the Charge Nurse. When a spill occurs, it should be cleaned up at that time. In addition to a routine cleaning schedule, everything should be cleaned on an as needed basis...

2. Observations on 1/23/12 beginning at 9:15 AM revealed the following:
   a. Room 201 - a large amount of dust balls on the floor under the head of the bed, beside the chair and under the bathroom sink.

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

**TITLE**

**DATE** 2-9-2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable w days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
F 253 Continued From page 1

b. Room 203 - a large amount of dust balls on the floor under the head of the bed, beside the chair and table. A feeding pump had a dried tan substance all along the top of the pump, base of pump pole, walls and ceiling above bed A.

c. Room 205 - a privacy curtain with multiple discolored stains and brown substances.

3. Observations on 1/23/12 beginning at 10:40 AM revealed the following:

a. Room 301 - bathroom floors with brown and black particles, the paper towel holder with a large amount of dust and grime type substance, plastic containers on the vanity with gross amount of dust and a dried white substance along the tops and sides. A feeding pump with a dried tan substance all along the top and sides of the pump and pump pole.

b. Room 304 - a gross amount of dust particles on the wall and behind the door and hinges and the bathroom sink with gross amount of white substance caked all over the faucet.

c. Room 305 - the bathroom vinyl floor curled up at the edge of the threshold approximately 6 inches long, dirt particles on the floor and black grimy substance build up in the corners and under the sink.

d. Room 306 - bathroom floors with multiple areas of a brown substance, a large amount of black grimy substance build up in the corners and black particles on the floor.

e. Room 310 - a large amount of black grimy substance build up in the corners of the bathroom, a dirty denture cup with moderate amount of brown substance on the exterior of the cup.

4. Observations on 1/23/12 beginning at 10:35
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<td>AM revealed the following:</td>
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<tr>
<td>a.</td>
<td>Room 501 - the sink and vanity in the room with a brown and black stained caulk around the sink, gross build up of a white substance caked around the faucet.</td>
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<td>b.</td>
<td>Room 502 - a large amount of dust balls on the floor under the head of A bed, and a 12 by (x) 2 inch area of shredded wallpaper at the head of the bed.</td>
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<td>c.</td>
<td>Room 503 - A and B beds feeding pump had a dried tan substance all along the top, sides, screen, pump pole, night stand, wall and ceiling.</td>
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<td>d.</td>
<td>Room 506 - the sink and vanity in the room with a brown and black stained caulk around the sink, gross build up of a white substance caked around the faucet.</td>
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<td>e.</td>
<td>Room 508 - a large amount of black grimy substance build up in the corners of the bathroom, tape stuck to the vanity, a gross amount of white substance caked all over the faucet, caulk around the faucet with brown substances in the caulk.</td>
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<tr>
<td>f.</td>
<td>Room 509 - a soiled wheelchair.</td>
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<td>g.</td>
<td>Room 510 - a large amount of dust balls on the floor under the head of the bed and beside the chair.</td>
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<td>5.</td>
<td>Observations on 1/23/12 beginning at 10:30 AM revealed the following:</td>
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<tr>
<td>a.</td>
<td>Room 601 - a large amount of dust balls on the floor under the head of the bed and beside the chair.</td>
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<tr>
<td>b.</td>
<td>Room 607 - a large amount of dust balls on the floor under the head of the bed and in front of the chest.</td>
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| c.   | Room 609 - a golf ball size hole in the bathroom vinyl floor covering, loose brown and black debris in the floor and various paper items.
F 253 Continued From page 3

A feeding pump with a dried tan substance all along the front of the pump and pump pole.

6. Observations in room 711 on 1/23/12 at 10:30 AM revealed a feeding pump with a dried tan substance all along the top, front and lever of the pump.

7. Observations on 1/24/12 beginning at 10:25 AM revealed the following:
   a. Room 705 - floor mat with slits, cracks and stuffing exposed, the bathroom elevated commode seat with brown colored substance on the front rail.
   b. Room 706 - wall paper behind the head of B bed with a 6x6 inch torn area, a 3 foot long cove base off the wall lying on the floor revealing old glue and dirt build up.
   c. Room 710 - wall paper to the left of the head board of B bed with a 12x2 inch torn area and a 6x6 inch jorm gaping area.
   d. Room 712 - a large amount of dust balls on the floor under the head of B bed, under the heating/cooling unit, in front of the closet, debris in the floor, paper pieces and brown and black substance on the bathroom floor.

8. During a tour and interview with the housekeeping supervisor on the 200, 300, 500, 600, 700 hall resident rooms on 1/24/12 at 10:40 AM, the housekeeping supervisor confirmed the unsanitary conditions of the feeding pumps and resident rooms and bathrooms. The housekeeping supervisor stated, "...This is unacceptable..."

During a tour and interview with the Administrator on the 200, 300, 500, 600, and 700 hall resident
F 253 Continued From page 4

rooms on 1/24/12 at 10:50 AM, the Administrator confirmed the unsanitary conditions of the feeding pumps and resident rooms and bathrooms. The Administrator stated, "...Yes, I see..."

9. Observations in Central Bath #1 on 1/24/12 at 8:00 AM revealed the following:
   a. A large golf ball size hair ball in the sink and a medicine cup under the vanity.
   b. Shower stall #1 - two black color firm solid substances lying in the stall floor, privacy curtain with multiple white substances caked on curtain.
   c. A shower chair with a blue mesh back had a black substance under the seat.
   d. Shower stall #2 - drinking straw and a dissolving wet napkin on the floor.
   e. A shower chair with a pink mesh back had a large amount of a dried black substance under the seat and on the chair frame.
   f. Bed side commode #1 - pail with gross amount of dried orange substance in the bottom.
   g. Bed side commode #2 - broken seat back and old tape around the foot.
   h. A blue sensor pad for a chair with a large amount of a black dried substance all over the pad.
   i. The privacy curtain leading into room had a gross amount of dried white substances caked on the curtain and dark discolored areas.

During an interview in Central Bath #1 on 1/24/12 at 8:00 AM, the Assistant Director of Nursing (ADON) was asked to look at the equipment in the central bath. The ADON stated, "...Yes, these curtains need to be cleaned..." The ADON confirmed all findings of the unsanitary room and equipment.
Continued From page 5

10. Observations in Central Bath #2 on 1/24/12 at 7:40 AM revealed the following:
   a. A shower chair with a white mesh back had a gross amount of black substances in the mesh, large amount of a dried brown substance smeared on top of the seat in 2 areas.
   b. A pommel cushion in a wheelchair with a "Bugle" chip and white particles in the seat.
   c. A shower stretcher pad with a large white film substance near the head area.
   d. Shower chair #1 with a pink mesh back had a gross amount of black substances in the mesh, gross amount of dried black and brown substance under the seat and on the chair frame.
   e. Shower chair #2 with a pink mesh back had a gross amount of black substances in the mesh, gross amount of dried black and brown substance under the seat and on the chair frame.
   f. A blue floor pad with large slit in pad and multiple holes with stuffing exposed. The pad was folded lying on top of the shower stretcher.
   g. A shower chair with a blue seat with a mesh type cover on seat had a large amount of brown stain discoloration.
   h. A maroon geri chair pad bad streaks of a white substance film on the back and the seat cushion with white dried particles.
   i. A bed side commode with right arm pad broken off completely revealing jagged edges.

During an interview in Central Bath #2 on 1/24/12 at 7:40 AM, the ADON was asked to look at the equipment in the central bath. the ADON stated, "...Yes, I see some stuff, it is filthy..." The ADON confirmed all the findings of the unsanitary room and equipment.

11. During an interview at the nurses' station on
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:

445262

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED

01/25/2012

NAME OF PROVIDER OR SUPPLIER

CUMBERLAND MANOR NURSING CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
4343 ASHLAND CITY HWY
NASHVILLE, TN 37218

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 253 Continued From page 6
1/24/12 at 9:40 AM, the Director of Nursing (DON) was asked who is responsible for cleaning the equipment in the shower rooms. The DON stated, "...It should be cleaned by nursing staff after each use with Supersani wipe or other disinfectant provided by housekeeping."

F 272 483.20(b)(1) COMPREHENSIVE ASSESSMENTS

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:
- Identification and demographic information;
- Customary routine;
- Cognitive patterns;
- Communication;
- Vision;
- Mood and behavior patterns;
- Psychosocial well-being;
- Physical functioning and structural problems;
- Continence;
- Disease diagnosis and health conditions;
- Dental and nutritional status;
- Skin conditions;
- Activity pursuit;
- Medications;
- Special treatments and procedures;
- Discharge potential;
- Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum

F 253

F 272

F 272 483.20 (b)(1) Comprehensive Assessments

Requirements:
The facility will conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

Corrective Action:
(1) On 2/1/12 a modification was completed to resident #3 comprehensive assessment dated 12/19/11 by the MDS coordinator.

(2) On 1/25/12, the MDS coordinators conducted chart audits to ensure MDS assessments were accurate and complete.

(3) On 1/25/12 an in-service was conducted by the Administrator and DON with the MDS Coordinators and RD regarding accuracy of MDS assessments.

(4) The DON, ADON, Risk Management nurse will monitor for compliance through random chart audits and report findings to the QA committee monthly.

Completion date: 2/2/12
F 272: Continued From page 7
Data Set (MDS); and
Documentation of participation in assessment.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation and interview, it was determined the facility failed to accurately assess the swallowing status on the Minimum Data Set (MDS) for 1 of 24 (Resident #3) sampled residents.

The findings included:

Medical record review for Resident #3 documented an admission date of 12/12/11 with diagnoses of Coronary Artery Disease with Remote Coronary Arterial Bypass Graft, Atrial Fibrillation, Pacemaker, Cerebral Vascular Accident, Hypertension, Hyperlipidemia, Prostate Cancer, History of Barrett's Esophagus, History of Peptic Ulcer, Agitation Dementia with Superimposed Delirium, and Depression. Review of the MDS dated 12/19/11 documented,
"...Section K Swallowing / Nutritional Status K0100. Swallowing Disorder Signs and symptoms of possible swallowing disorder... Z. None of the above..." was marked.

Observation in Resident #3's room on 1/23/12 at 3:00 PM, revealed Resident #3 sleeping with his mouth open and he began coughing vigorously.
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<td>F 272</td>
<td>During an interview in Resident #3's room on 1/23/12 at 3:00 PM, a family member stated, &quot;...he does that often [referring to the coughing] as he has swallowing problems and is on thickened liquids...&quot;</td>
<td>F 272</td>
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<td>F 279</td>
<td>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</td>
<td>F 279</td>
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<td>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</td>
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<td>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.</td>
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<td>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).</td>
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<td>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 to reflect the swallowing status of 1 of 26 (Resident #3) sampled residents.</td>
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### Summary Statement of Deficiencies

Review of the facility's "Comprehensive Care Plans" policy documented, "...The care plan must be completed within 7 days after comprehensive assessment or within 21 days of admission..."

Medical record review for Resident #3 documented an admission date of 12/12/11 with diagnoses Coronary Artery Disease with Remote Coronary Arterial Bypass Graft, Atrial Fibrillation, Pacemaker, Cerebral Vascular Accident, Hypertension, Hyperlipidemia, Prostate Cancer, History of Barrett's Esophagus, History of Peptic Ulcer, Agitation Dementia with Superimposed Delirium, and Depression. The facility was unable to provide a comprehensive care plan on 1/23/12. Review of the physician's order dated 1/17/12 documented, "...Regular diet c [with] NTL [nectar thick liquids]." Review of the comprehensive care plan dated 12/30/11, but not present in the medical record until 1/24/12, documented no swallowing problem or nectar thick liquids.

Observation in Resident #3's room on 1/23/12 at 3:00 PM, revealed Resident #3 sleeping with his mouth open and he began coughing.

During an interview in Resident #3's room on 1/23/12 at 3:00 PM, a family member stated, "...he [Resident #3] does that often [referring to the coughing] as he has swallowing problems and is on thickened liquids..."

During an interview at the nurses' station on 1/24/12 at 9:25 AM, the Director of Nursing (DON) was asked about the missing comprehensive care plan. The DON stated,
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"...She is in the process of doing his care plan..."

During an interview in the DON's office on 1/25/12 at 10:55 AM, the DON was asked if she would expect nectar thick liquids and the reason for its use to be care planned. The DON stated, "...I would expect specifics related to the resident to be care planned..."