STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA IDENTITY NUMBER:
445170

(X2) MULTIPLE CONSTRUCTION:
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
08/25/2010

GOOD SAMARITAN HEALTH AND REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
500 HICKORY HOLLOW TERRACE
ANTIOCH, TN 37013

(X4) ID PREFIX TAG
F 258
SS=E

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

F 258
483.15(b)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS

The facility must provide for the maintenance of comfortable sound levels.

This REQUIREMENT is not met as evidenced by:

Based on review of resident council minutes, observation and the group interview, it was determined the facility failed to maintain comfortable sound levels for 5 of 7 alert and oriented residents Random Residents (RR) #3, 4, 5, 6 and 7) participating in the group interview.

The findings included:

1. Review of the February 2010 resident council minutes documented, "Techs are being too loud in morning."

2. Observations during the initial tour of the 300 hall on 8/23/10 at 10:25 AM, a Certified Nursing Technician (CNT) was yelling down the hallway to another CNT.

3. During the group interview in the fine dining room on 8/23/10 at 3:00 PM, five alert and oriented residents voice the following:
   a. RRs #3, 4, 5 and 6 complained of "...noisy when staff getting off in the morning and when passing out the meal trays..."
   b. RR #7 stated, "I would really like to see the

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 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.

FORM OMS-2587(02-09) Previous Versions Obsolete
Event ID: 0TLC011
Facility ID: TN1909
If continuation sheet Page 1 of 8
F 258
483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS

The facility must provide for the maintenance of comfortable sound levels.

This REQUIREMENT is not met as evidenced by:
Based on review of resident council minutes, observation and the group interview, it was determined the facility failed to maintain comfortable sound levels for 5 of 7 alert and oriented residents Random Resident (RR) #3, 4, 5, 6 and 7 participating in the group interview.

The findings included:
1. Review of the February 2010 resident council minutes documented, "Techs are being too loud in morning."

   Review of the March 2010 resident council minutes documented, "...Too loud in mornings: staff and carts. Has been reported but nothing done..."

2. Observations during the initial tour of the 300 hall on 8/23/10 at 10:25 AM, a Certified Nursing Technician (CNT) was yelling down the hallway to another CNT.

3. During the group interview in the fine dining room on 8/23/10 at 3:00 PM, five alert and oriented residents voice the following:
   a. RRs #3, 4, 5 and 6 complained of "...noisy when staff getting off in the morning and when passing out the meal trays..."
   b. RR #7 stated, "I would really like to see the..."

- Any other findings will be discussed for further corrections or resolutions to ensure that the sound levels do not interfere with residents’ hearing or communication and may enhance privacy as desired, as well as, encourage a better social interaction.

What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and

- Continued monitoring by charge nurses, supervisors, DON and all IDT members to maintain comfortable noise levels throughout the facility.

- Continue to receive feedback from residents.

- The Director of Staff Development (DSD) will continue to in-service staff found to be non-compliant.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

- Any problems related to this issue will be monitored by IDT members during daily QA rounds utilizing the daily QA rounds tool.

- All identified issues will be presented at the daily QA meeting for discussion/resolution as needed.

- Give and receive updates at the residents Monthly Resident Council Meeting.

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

[Signature]

TITLE

Administrator

DATE

9/9/2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are discloseable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are discloseable 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.
<table>
<thead>
<tr>
<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tbody>
<tr>
<td>F 258</td>
<td>463.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS</td>
<td></td>
<td>The facility must provide for the maintenance of comfortable sound levels.</td>
<td>F 258</td>
<td></td>
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<td>- Random interviews will be included during each care plan conference for ongoing monitoring with residents and families (if present) for feedback of noise levels.</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on review of resident council minutes, observation and the group interview, it was determined the facility failed to maintain comfortable sound levels for 5 of 7 alert and oriented residents Random Residents (RR) #3, 4, 5, 6 and 7 participating in the group interview.</td>
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<td>- The Maintenance Supervisor will continue to periodically monitor all equipment for noise level compliance, including the meal carts.</td>
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<td>The findings included: 1. Review of the February 2010 resident council minutes documented, &quot;Techs are being too loud in morning.&quot; Review of the March 2010 resident council minutes documented, &quot;...Too loud in mornings: staff and carts. Has been reported but nothing done...&quot;</td>
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<td>- The Administrator will also monitor sound levels during his daily QA rounds to ensure absence of unwanted noise from equipment, music and staff's behavior of hallway traffic.</td>
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<td>2. Observations during the initial tour of the 300 hall on 8/23/10 at 10:25 AM, a Certified Nursing Technician (CNT) was yelling down the hallway to another CNT.</td>
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| | | | 3. During the group interview in the fine dining room on 8/23/10 at 3:00 PM, five alert and oriented residents voice the following: a. RRs #3, 4, 5 and 6 complained of "...noisy when staff getting off in the morning and when passing out the meal trays..." b. RR #7 stated, "I would really like to see the

- deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patient. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
### Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
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<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 258</td>
<td>Continued From page 1 noise issue really worked on.</td>
<td>F 258</td>
<td>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</td>
<td>8/26/10</td>
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<td>F 280</td>
<td>483.20(d)(3), 483.10(k)(2) Right to Participate Planning Care-Revise CP</td>
<td>F 280</td>
<td>- Immediately the Care Plan of resident #13 was reviewed and updated by the IDT in conjunction with the resident's clinical needs and according to the rules and regulation to attain the residents' highest practicable physical, mental and psychosocial well being.</td>
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The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

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

This REQUIREMENT is not met as evidenced by:
Based on medical record review and an interview, it was determined the facility failed to revise the care plan for emergency bleeding for 1 of 20 (Resident #13) sampled residents.

The findings included:
Medical record review for Resident #13
Continued From page 1
noise issue really worked on.

c. RR #3 stated the noise was worse "between 6:30 AM and 7:15 AM [staff are] laughing and
talking."

483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless unjudged
incompetent or otherwise found to be
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for the resident, and other appropriate staff in
disciplines as determined by the resident's needs,
and, to the extent practicable, the participation of
the resident, the resident's family or the resident's
legal representative; and periodically reviewed
and revised by a team of qualified persons after
each assessment.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and an interview,
the hospital failed to revise the
the care plan for emergency bleeding for 1 of 20
(Resident #13) sampled residents.

The findings included:

Medical record review for Resident #13
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<tr>
<td>F 280</td>
<td>Continued From page 2 documented an admission date of 8/19/10 with diagnosis of Chronic Obstructive Pulmonary Disease, Hypertension, End Stage Renal Disease with Hemodialysis, Peptic Ulcer Disease, Congestive Heart Failure and Peripheral Vascular Disease. Review of the physician's orders dated 8/20/10 documented, &quot;...Dialysate at [named hospital] in Nashville on Tues [Tuesday], Thursday, &amp; [and] Saturday.&quot; Review of the physician's orders dated 8/20/10 documented, &quot;Monitor Dialysate Site Left Arm (Britt [Blood] And Thrill) For S/S [signs and symptoms] of Infection, Bleeding...&quot; Review of the initial care plan dated 8/19/10 revealed no documentation of interventions for emergency bleeding, During an interview in the Director of Nursing's (DON) office on 8/26/10 at 10:00 AM, Nurse #5 was asked if Resident #13's plan of care addressed emergency bleeding. Nurse #5 stated, &quot;Monitor the site for bleed but not the next steps. It's not on there. I failed to add that. I'll get it fixed.&quot;</td>
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<td>F 441</td>
<td>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;</td>
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<tr>
<td>SS-D</td>
<td>483.05 Infection Control, Prevent Spread, Linens</td>
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<td>The MDS Coordinator will monitor the written plan of care in relation to residents' needs as identified in the comprehensive assessment prior to signing the MDS and Care Plan Conferences. Care Plans to be periodically reviewed, updated or revised quarterly, annually and as necessary by a team of qualified staff with MDS Coordinator to ensure accuracy and completeness. Medical records staff will monitor Plan of Care as part of their routine audit for compliance. The DON will randomly monitor care plans for completeness and compliance during her bimonthly QA chart audit. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Attention of the concerned staff was called immediately upon notification of the deficient practice. One-on-one counseling and in-services were given regarding infection control with emphasis on hand washing technique.</td>
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<td>ID</td>
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<td>F 441</td>
<td>Continued From page 3</td>
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<td>F 441</td>
<td>Continued from page 4</td>
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<td>#8’s blood sugar level, removed the gloves and cleaned her hands with hand sanitizer. Nurse #2 returned to the medication cart and drew up the Novolin R insulin for an injection. Nurse #2 entered Resident #8’s room and washed her hands. Nurse #2 turned the water off with her bare hand and then dried her hands. Nurse #2 donned gloves, administered the injection of insulin into the abdomen of Resident #8, removed her gloves, and returned to the medication cart. Nurse #2 did not wash her hands after removing her gloves.</td>
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During an interview at the nurse’s station on 8/25/10 at 11:05 AM, the Director of Nursing (DON) was asked when would she expect a nurse to wash her hands. The DON stated, “It is our practice to wash hands when going into a room, after providing care, after removing gloves and before leaving the room.”

2. Observations during a dressing change in Random Resident (RR) #1’s room on 8/23/10 at 4:55 PM, revealed Nurse #1 washed his hands, pulled the curtain, donned gloves, assisted in turning RR #1, removed his gloves, donned another pair of gloves and proceeded to clean the wound. Nurse #1 did not wash his hands between assisting RR #1 to turn and starting the dressing change.

3. Observations in RR #2’s room on 8/24/10 at 2:30 PM, Nurse #1 performed a dressing change on RR #2. After Nurse #1 washed his hands in RR #2’s restroom, he returned to the hallway and opened the treatment book and then the treatment cart. Nurse #1 then removed a biohazard bag and scissors and to cut the bag in half. Half of the bag was used for trash and the

<table>
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<th>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.</th>
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<td>- All staff will be monitored by DSD and/or IDT members during daily QA rounds to ensure infection control procedures are followed.</td>
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<td>- Counseling and/or disciplinary action will be given to staff failing to follow procedures.</td>
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<tr>
<td>F 441</td>
<td>Continued From page 5: other half was used for a clean barrier for the supplies. Nurse #1 removed the Alewyn dressing, single sterile 2 by (x) 2 gauze dressing package and Multidex Powder. Nurse #1 applied the Multidex Powder to the opened 2x2 gauze, opened the Alewyn dressing and then opened the treatment cart to remove a single sterile 4x4 gauze. Nurse #1 removed a bottle of Normal Saline (NS) from the treatment cart and applied NS to the 4x4 gauze. Nurse #1 then entered RR #2's room, donned clean gloves and removed the old dressing, placed the old dressing in the biohazard bag, removed gloves and donned another pair of clean gloves without washing his hands. During an interview at the Nurse's Station on 8/25/10 at 9 AM, Nurse #1 confirmed the lack of handwashing.</td>
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<td>F 514</td>
<td>483.75(i)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</td>
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</table>

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>F 514</td>
<td>Continued From page 6</td>
<td>Based on medical record review, observations and interviews, it was determined the facility failed to ensure bowel movements were accurately documented for 2 of 20 (Residents #1 and 6) sampled residents. The findings included:</td>
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1. Medical record review for Resident #1 documented an admission date of 4/19/10 with diagnoses of Anxiety State, Gastroesophageal Reflux Disease, Chronic Obstructive Pulmonary Disease, Senile Dementia, Congestive Heart Failure and Hypertension. Review of Resident #1's August 2010's "Nurse Aides Notes" revealed no bowel movements were documented from 8/4/10 through 8/15/10 for Resident #1. During an interview at the nurse's station on 8/24/10 at 2:40 PM, Certified Nursing Assistant (CNA) #4 stated, "She [Resident #1] does not go over 3 days without a BM [bowel movement]. ...She [Resident #1] tells us when she wants to go. If she did not have a BM, I would tell the nurse."

2. Medical record review for Resident #6 documented an admission date of 10/1/09 with diagnoses of Chronic Constipation, Diabetes Mellitus, Dementia, and Osteopenia. Review of Resident #6's August 2010's "Nurse Aides Notes" for the 2:30 AM to 11:00 PM revealed Resident #6 had no bowel movement documented from 8/20/10 through 8/24/10. Observations in Resident #6's room on 8/23/10 at 4:10 PM, revealed Resident #6 sitting on the mattress on the floor. Resident #6 pulled her pants and diaper off revealing a bowel movement. |

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<tr>
<td>F 514</td>
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<td>08/26/2010</td>
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How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

- Inclusion of maintaining clinical records of residents during their orientation period that are accurate and complete.

What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and

- During Orientation period of staff and care givers, the DSD will include clinical documentation of residents as part of their important function in their daily care. Documentation will reflect the actual condition of the resident, must be accurate and realistic providing a true picture of the residents for the day.

- The DSD or her designee will monitor the CNA’s ability to document appropriately by auditing their daily documentation. Any findings will be corrected immediately.

- Charge nurses will follow up on CNA’s bowel documentation utilizing the daily bowel monitoring form.
### Continued From page 7

in the diaper. Certified Nursing Technicians (CNT) #1 and 3 cleaned Resident #6 and changed her clothes.

During an interview at the nurse’s station on 8/24/10 at 12:15 PM, Nurse #3 was asked where a resident's bowel movement would be documented. Nurse #3 stated, "...The CNT writes it [bowel movement] down on the aide notes. After reviewing the August 2010 nurse aide notes. Nurse #3 stated, "The CNT didn’t write it [bowel movement] down."

During an interview at the nurse’s station on 8/24/10 at 4:00 PM, CNT #1 reviewed the August 2010 nurse aide notes. CNT #1 stated, "I know she [Resident #6] had a BM yesterday. It [bowel movement] didn’t get wrote in on the sheet."

### F 514

How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

- Medical records staff will monitor the CNA’s documentation records as part of their routine audit for compliance.
- The DOS will monitor for accuracy and completeness during her daily QA audit.
- The DON will randomly monitor the CNA’s documentation for completeness, accuracy and compliance.
- Additional monitoring will be conducted through the monthly QA meeting.