F 276: November 7th, 2009

1. RI # 12 MDS has been corrected to accurately reflect residents status.

2. Residents who triggered for falls on the QI/QM report have the potential to be affected by the alleged deficient practice.

3. Resident Care Management Director or designee to audit all residents that trigger for falls on QI/QM report for the next 90 days to ensure all are accurately coded on their MDS.

   MDS staff and Director of Nursing to be re-educated by the Regional Care Management Coordinator on proper coding of the MDS assessments.

The assessment must accurately reflect the resident’s status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment, or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interviews, it was determined the facility failed to ensure the Minimum Data Set (MDS) revealed the correct assessment for falls for 1 of 24 (Resident #12) sampled residents.

The findings included:

The findings included:
All falls will be reviewed during morning clinical meeting and DON/designee to ensure falls are correctly reflected in MDS assessments completed each week.

4. Director of Nursing/designee will report any identified trends to Quality Assessment & Assurance meeting monthly X 90 days

F 280: November 7th, 2009

1. RF# 1 care plan was updated and reflected current status
RF# 8 care plan was updated and now reflects current hospice status and psychiatric services.
RF# 14 care plan was updated and now reflects current medications and interventions for wound treatments.

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.
F 280  Continued From page 2
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 resident care plan for psychiatric services, fall
interventions or medications for 3 of 24
(Residents #1, 8 and 14) sampled residents.

The findings included:

1. Medical record review for Resident #1
documented an admission date of 6/24/09 with
diagnoses of Chronic Obstructive Pulmonary
Disease, Hypertension, Alzheimer’s Disease,
Parkinson’s Disease, Osteoarthritis, Hiatal
Hernia, Benign Prostate Hypertrophy and
Diabetes Mellitus. Review of the change of condition forms documented Resident #1
sustained a fall on 6/25/09, 6/26/09, 6/27/09,
7/7/09, 7/15/09, 8/6/09, 8/15/09 and two falls on
9/17/09. Review of the care plan dated 7/8/09 and
reviewed on 10/1/09 documented no new
interventions for the fall sustained on 7/7/09.

2. During an interview in the conference room on
10/7/09 at 2:25 PM, the Director of Nurses (DON)
was asked about interventions for the fall on
7/7/09. The DON stated, "...was missed [the fall on 7/7/09]...nurse filled out the paperwork...didn't
get done [intervention for the fall on 7/7/09]."

3. Medical record review for Resident #8
documented an admission date of 9/17/03 with
Resident with the potential to be affected by
the alleged deficient practice
Residents that have had a
fall, hospice residents
and/or residents with
wounds.

-Resident Care
Management Director and
Wound Care Nurse
reviewed all residents
with current wounds to
ensure that current care
plans are accurately
reflective of current
wound treatments.

-Director of Nursing, Unit
Managers and Resident
Care Management
Director reviewed all
residents with falls care
plans to ensure all care
plans currently reflect
accurate interventions.

Director of Nursing/designee will re-
educate license staff on
updating care plans.
**Name of Provider or Supplier:**
GREENHILLS HEALTH AND REHABILITATION CENTER

**Street Address, City, State, Zip Code:**
3088 HILLSBORO CIRCLE
NASHVILLE, TN 37215

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<tr>
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<td>X2</td>
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<tr>
<td>X3</td>
<td>DATE SURVEY COMPLETED</td>
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**ID | PREFIX/Tag | Provider's Plan of Correction | Completion Date**
---|---|---|---
| F 280 | | immediately at the time of an event. |
| F 280 | | Resident events identified on the 24-hour report will be reviewed by Inter disciplinary team during morning meeting for appropriate care plan interventions. |
| | | Action team to review residents with wounds weekly to ensure updates are reflected in care plans. |
| | | All new hospice residents will be brought to morning meeting for review of care plan updates following their admission to hospice. |
| | | Director of Nursing/designee will report any identified trends to Quality Assurance Committee monthly X 3. |
| F 309 | 483.25 QUALITY OF CARE |
| | | 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 and interview, it was determined the facility failed to provide a plan |

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<td>105311</td>
<td>TN1916</td>
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of care for coordination of hospice services for 1 of 3 (Resident #8) sampled residents receiving hospice care.

The findings included:

Medical record review for Resident #8 documented an admission date of 9/17/03 with diagnoses of Senile Dementia, Psychosis, Hypertension and Dysphagia. A physician's order dated 9/1/09 documented to begin hospice care for comfort measures related to failure to thrive. Review of the plan of care reviewed 7/23/09 revealed there was no plan of care to address the coordination of hospice care with the facility.

During an interview in the conference room on 10/7/09 at 2:20 PM, the Director of Nursing stated, "We made a mistake. It [hospice care] has been added to the care plan today [10/7/09]."

F 323 483.25(h) ACCIDENTS AND SUPERVISION

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to implement new interventions after falls for 1 of 9 (Residents #1) sampled residents with multiple falls.

The findings included:

F 309 309: November 7th, 2009

1. RI# 8 care plan is currently accurate and reflects hospice status and changes in psychiatric services.

2. Any resident currently under hospice services have the potential to be affected by the alleged deficient practice.

3. All newly admitted hospice resident's care plan will be reviewed in the morning meeting by the interdisciplinary team for appropriate care plan interventions and communication.

4. Director of Nursing/designee will report any identified trends to Quality Assurance Committee monthly X 3.
Medical record review for Resident #1 documented an admission date of 6/24/09 with diagnoses of Chronic Obstructive Pulmonary Disease, Hypertension, Alzheimer's Disease, Parkinson's Disease, Osteoarthritis, Hiatal Hernia, Benign Prostate Hyper trophy and Diabetes Mellitus. Review of the change of condition forms documented Resident #1 had falls as followed:

a. 6/25/09 at 9:30 PM, "...found lying in front of w/c [wheelchair]. [no] Injury noted."

b. 6/26/09 at 1:00 PM, "...Observed Resident lying down on the floor...Small skin Tear noted." 

c. 6/27/09 at 2:00 PM, "...Observed, Resident lying down on floor... [no] c/o [complaint] of pain or discomfort..." 

d. 7/7/09 at 7:00 PM, "...slipped off bed onto buttock..." skin tear to right elbow.

e. 7/15/09 at 8:00 AM, "...Observed Resident lying on the floor... [no] Injury noted..." 

f. 8/5/09 at 1:00 PM, "...Observed Resident lying on the floor beside Bed... [no] Injury noted..." 

g. 8/15/09 at 7:45 PM, "...Resident was observed on the floor, supine, near the door..." 

h. 9/17/09 at 2:30 PM, "...Resident was sitting in a small w/c...he leaned back and fell to the floor...Note hematoma to the back of the head..." 

i. 9/17/09 at 4:10 PM, "...Pt [patient] was placed in a regular w/c...Pt was able to tip over regular w/c in dayroom. Pt hit head again..."

Review of the care plan dated 7/8/09 and reviewed on 10/1/09 documented no new interventions for the fall Resident #1 sustained on 7/7/09.

During an interview in the conference room on 10/7/09 at 2:25 PM, the Director of Nurses was asked about the intervention for the fall on 7/7/09.

1. RI # 1 care plan has been updated to accurately reflect current interventions.

2. All residents with falls have the potential to be affected by the alleged deficient practice.

3. Director of Nursing/designee will re-educate license staff on updating care plans immediately at the time of an event.

Resident events identified on the 24-hour report will be reviewed by Inter disciplinary team during morning meeting for appropriate care plan interventions.

4. Director of Nursing/designee will report any identified trends to Quality Assurance Committee monthly X 3.
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The DON stated, "...was missed [implementing a new intervention for the fall on 7/7/09]...nurse filled out the paperwork... didn't get done (new intervention put in place for the fall on 7/7/09)..."

**F 326 483.25(k) SPECIAL NEEDS**

The facility must ensure that residents receive proper treatment and care for the following special services:
- Injections;
- Parenteral and enteral fluids;
- Colostomy, ureterostomy, or ileostomy care;
- Tracheostomy care;
- Tracheal suctioning;
- Respiratory care;
- Foot care; and
- Prostheses.

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

Based on medical record review, observations and an interview, it was determined the facility failed to provide oxygen (O2) at the correct rate or obtain a physician’s order for O2 for 2 of 5 (Residents #11 and 20) sampled residents reviewed requiring O2.

The findings included:


2. All residents that received O2 have the potential to be affected by the alleged deficient practice.

3. Director of Nursing/designee to educate staff on how to correctly set liters per minute on the Oxygen concentrators. Licensed nurse to document every shift on the treatment administration record for residents with O2 ordered, indicating
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Observations in Resident #11’s room on 10/5/09 at 9:30 AM and 1:35 PM and on 10/7/09 at 8:30 AM, revealed Resident #11 receiving O2 per nasal cannula at 2L/min. On 10/5/09 at 9:50 AM, the Unit Manager for the 3rd floor went into Resident #11’s room with the surveyor and verified Resident #11’s O2 was set at 2L/min. The Unit Manager changed Resident #11’s O2 to the correct rate of 3L/min.

2. Medical record review for Resident #20 documented an admission date of 10/31/08 with diagnoses of Congestive Heart Failure, Malaise, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, Morbid Obesity, Hypertension, Renal Insufficiency, Osteoarthritis and Sleep Apnea. Review of the physician’s orders dated 10/8/09 revealed there was no documented order for Resident #20 to receive O2.

Observations in Resident #20’s room on 10/7/09 at 8:40 AM and 1:50 PM, revealed Resident #10 lying in bed receiving O2 at 3L/min per nasal cannula.

During an interview in the first floor medication storage room on 10/7/09 at 2:05 PM, the second floor Unit Manager stated, “...she (Resident #20) is on oxygen... the pharmacy left it [O2] off [of the current re-certification orders].”

F 328

current physician orders are being followed appropriately.

Director of Nursing/designee to audit 50% of residents with Oxygen orders weekly X 4, then monthly X 2.

4. Director of Nursing/designee will report any identified trends to Quality Assurance Committee monthly X 3.