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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER CLIA IDENTIFICATION NUMBER
445460

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
04/19/2013

NAME OF PROVIDER OR SUPPLIER
VANCO MANOR NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
813 S DICKERSON RD
GOODLETTSVILLE, TN 37072

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-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 000 INITIAL COMMENTS

During the annual recertification survey conducted April 15 - 19, 2013 two complaints #29634 and #31133 were also investigated. Deficiencies were cited for both complaints under 42 CFR PART 482.13, Requirements for Long Term Care.

F 242

F 242

483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES

The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, the facility failed to allow one resident (#27) to make a choice for the time of day a bath was received of thirty-three residents reviewed.

The findings included:
Resident #27 was admitted to the facility on February 28, 2013, with diagnoses including Diabetes, Coronary Artery Disease, Hypertension, Gastroesophageal Reflux Disease, Diverticulosis, Alzheimer's Dementia, Hypothyroidism, Mixed Anxiety and Depression.

Medical record review of the admission Minimum Data Set (MDS) dated March 8, 2013, revealed a

ABSORARY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are discardable 90 days allowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are discardable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite for continued program participation.
F 242  Continued From page 1

score of fifteen on the Brief Interview for Mental Status (BIMS), indicating the resident was independent with daily decision making. Continued review of the MDS revealed the resident required limited assistance of one person with bed mobility, transfers, dressing, toilet use, and personal hygiene, and required physical help of one person in part of the bathing activity.

Interview with the resident on April 15, 2013, at 2:58 p.m., in the resident's room, revealed the resident would like a shower in the morning instead of the evening. Continued interview revealed the resident was scheduled to receive showers on the evening shift.

Interview on April 17, 2013, at 1:50 p.m., with Certified Nursing Assistant (CNA) #5 (responsible for the resident's care) revealed the resident was scheduled to receive a shower on the second shift, and shower times were scheduled or given by the resident's preferences obtained by social services.

Interview on April 17, 2013, at 2:00 p.m., with the Director of Nursing, in the conference room, revealed the facility had a schedule for showers based on whether the resident was in the A bed or B bed. Continued interview revealed if the family member or resident did not want a shower scheduled their request would be honored. Continued interview confirmed no assessment as to the time of day resident #27 would prefer to receive a shower.

Interview on April 17, 2013, at 2:10 p.m., with the Admissions Coordinator, in the admission office,

3.) Admissions Coordinator in-service by ADON on 5-6-13 to ask resident preferences along with families on admission, and take information to MDS for care planning.

4.) DON/ADON and admissions nurse to audit charts and interview residents upon admission to ensure guidelines are followed. Started 4-23-13 weekly for one month then Quarterly.

Completion 6/10/13
F 242 Continued From page 2
revealed when the resident was admitted to the facility, the resident's daughter was asked about the resident's customary routines and bathing in the evening was not the resident's customary routine. Continued interview revealed the Admissions Coordinator had not asked resident #27 if the resident preferred showers in the morning or evening.

F 248
483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES

The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, review of the Activity Schedules, and interview, the facility failed to provide activities to meet the needs of one (#27) resident of thirty-three residents reviewed.

The findings included:
Resident #27 was admitted to the facility on February 28, 2013, with diagnoses including Diabetes, Coronary Artery Disease, Hypertension, Gastroesophageal Reflux Disease, Diverticulosis, Alzheimer's Dementia, Hypothyroidism, Mixed Anxiety and Depression.

Medical record review of the admission Minimum Data Set (MDS) dated March 6, 2013, revealed a score of fifteen on the Brief Interview for Mental
From: VANCO MANOR NURSING AND REHABILITATION CENTER

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(X5) COMPLETION DATE

F 248 Continued From page 3

Status (BIMS), indicating the resident was independent with daily decision making.
Continued review of the MDS revealed the resident required limited assistance of one person with bed mobility, transfers, dressing, toilet use, and personal hygiene, and required physical help of one person in part of the bathing activity.

Medical record review of the Admission Activity Assessment dated March 1, 2013, revealed the resident had past interest of religious services or practices, music/singing, and was willing to try new activities to keep active.

Interview with the resident, in the resident’s room, on April 15, 2013, at 2:54 p.m., revealed there were no activities available in the evenings and sometimes the resident was bored.

Observation on April 17, 2013, at 10:50 a.m., revealed the resident in the main dining room and had participated in an activity and the residents were being offered hydration.

Interview and review of the Activity Schedules on April 17, 2013, at 11:05 a.m., with the Activity Director, in the conference room, confirmed there were no activities offered after 3:00 p.m., in January and February 2013, two activities were offered after 3:00 p.m., in March 2013, and one activity was offered after 3:00 p.m., April 1-17, 2013.

F 272 483.20(b)(1) COMPREHENSIVE ASSESSMENTS

The facility must conduct initially and periodically a comprehensive, accurate, standardized

F 272 SS=D

483.20(b)(1) COMPREHENSIVE ASSESSMENTS
F 272  Continued From page 4
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 Data Set (MDS); and
- Documentation of participation in assessment.

This REQUIREMENT is not met as evidenced by:

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

Corrective Action:
1.) Resident#74 was a closed record and was discharged home.
2.) All admissions have been reviewed by DON/ADON on 4-22-13 to ensure pain assessments have been completed.
3.) In-services completed on 4-22-13 by DON/ADON with Medicare Nurses and Charge Nurses to complete a pain assessment.
4.) DON/ADON to audit all new and readmissions weekly for three (3) months starting on 4-22-13. Results of audit will be discussed during QA Mtg. daily for one (1) month then Quarterly with QA Committee:
   Administrator, DON, ADON,
   Medical Director, Admissions Coordinator, Medical Records Nurse, Register Dietician,
   Therapy Director, Social Services, and MDS Coordinators.

Completion Date: 6/10/13
F 272 Continued From page 5

Based on medical record review, facility policy review, and interview, the facility failed to conduct a comprehensive pain assessment for one (#74) of thirty-three residents reviewed.

The findings include:

Resident #74 was admitted to facility on March 8, 2013, with diagnoses to include Atrial Fibrillation, Chronic Pain, Diabetes Mellitus, Hypertension, Irritable Bowel Syndrome, and Frequent Falls.

Review of the History & Physical from a hospital admission dated February 28, 2013, revealed "...has severe arthritis all over body as well as tenderness in knees from those fatty deposits, which I wonder if the arthritis may be flaring..."

Review of a consultation report dated March 4, 2013, revealed "...the patient complains of generalized body pains, joint pains, which has been going on for many years..."

Review of admission orders revealed the resident was ordered Lortab (narcotic pain medication) 10/325 mg (milligrams) every six hours and Oxycontin (narcotic pain medication) 10 mg BID (twice per day).

Review of the Medication Administration Record (MAR) for March 2013, revealed the resident received Lortab 10 mg on March 12, 15, 17, 18, 23, 28, 2013. Continued review of the MAR revealed the location of the pain and results of the pain medication documented on March 12, 15, 17, 18.

Review of the Admission Care Plan revealed pain
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| F272 |        |     | Continued From page 6 was addressed as a concern and interventions were put in place. Continued review revealed no pain assessment completed upon admission. Review of the facility policy entitled Pain Management revealed "...pain assessments will be monitored on admission and quarterly. The Pain Assessment Flow Charts are to be utilized for any complaints or signs and symptoms of pain..." Interview on April 18, 2013, at 3:15 p.m. with the Director of Nursing (DON) in the DON's office, revealed no pain assessment was completed. | F272  483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  

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 disagreements do not constitute a material and false statement. | 04/19/2013 |
### 278

**Summary Statement of Deficiencies**

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

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- 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 interview, the facility failed to accurately complete the Minimum Data Set for two resident's #109 and #182 of thirty-three residents reviewed.

  - The findings included:

    - Resident #109 was admitted to the facility on June 6, 2012, with diagnoses of Rehabilitation Process, Alzheimer's Disease, Muscle Weakness, Abnormality of Gait, Hypertension, Pressure Ulcer, Unspecified Site, Diabetes Mellitus, and Hypertension.

    - Medical record review of the quarterly Minimum Data Set (MDS) dated December 23, 2012, revealed the resident had a stage IV pressure ulcer, site unspecified, and no other pressure ulcers were addressed.

    - Medical record review of the Nurse's admission assessment dated June 6, 2012, revealed the resident was admitted with a stage IV sacral pressure ulcer, and bilateral stage II heel wounds.

    - Interview with the MDS Coordinator, RN #1, on April 18, 2013, in the MDS Coordinator's office, at 1:40 p.m., confirmed the sacral wound was the only wound listed on the MDS, and the bilateral

**Corrective Action:**

1. MDS Coordinators reassessed resident #109 and #182. Care Plan re-addressed to reflect resident #109's condition. MDS modified on resident #182 to reflect current condition. Completed 4-18-13.

2. MDS Coordinators audited all MDS and Care Plans to ensure all assessments are accurate and reflects such accuracy in the Care Plans by 5/1/13.

3. MDS Coordinators have been in-service by DON/ADON on 4-18-13 on documentation of their assessments of all residents to reflect all conditions and changes that pertain to all residents.

4. DON/ADON will monitor for compliance through monthly audits for three (3) months then quarterly for six (6) months to ensure care plans reflect resident current conditions. Started 4-22-13. The results will be reviewed in the Quarterly Assurance Committee meeting adjustments will be made as indicated.

**Completion Date:** 5/10/13
| F 278 | Continued From page 8  
|       | heel wounds had not been assessed.  
|       | Resident #182 was admitted to the facility on March 23, 2013, with diagnosis including Cerebral Vascular Disease, Hypertension, and Seizure Disorder.  
|       | Medical record review of the Admission Minimum Data Set (MDS) dated March 30, 2013 revealed no identified dental issues.  
|       | Medical record review of the Registered Dietitian Nutrition Assessment dated March 23, 2013, revealed the resident had own teeth and missing many teeth.  
|       | Observation and interview with Resident #182 on April 16, 2012, at 8:30 a.m., in the resident's room, revealed the resident had loose and missing teeth, and would like to see a dentist.  
|       | Interview with MDS Coordinator #2 on April 17, 2013, at 3:45 p.m., in the MDS Office, confirmed the resident had loose and missing teeth and the MDS was not accurate.  
| F 279 | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  
| SS=E  | 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 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.
F 279 Continued From page 9

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 medical record review and interview, the facility failed to develop a comprehensive care plan for five (#66, #130, #26, #189, #13) of thirty-three residents reviewed.

The findings included:

Resident #66 was admitted to the facility on September 12, 2012 with diagnoses to include Dementia, Lung Cancer, Hypertension, Chronic Kidney Disease.

Review of diagnostic study results revealed a Renal ultrasound performed on April 11, 2013, demonstrated moderate bilateral hydrenephrosis.

Medical record review of a physician's order dated April 12, 2013, revealed a urinary catheter to be inserted due to significant worsening of renal function; Nephrology consult.

Review of the care plan revealed the insertion of the urinary catheter and care of the catheter were not addressed in the care plan.

F 279

exercise of rights under 483.10, including the right to refuse treatment under 483.10(b)(4).

Corrective Action:

1.) The MDS coordinators reviewed and corrected Care Plans for residents #66, #130, #26, #13 to show accurate information on 4-19-13. Resident #189 had been discharged.

2.) The DON/ADON and MDS Coordinators completed chart audits on 4/26/13 for facility residents to ensure comprehensive assessments were completed correctly.

3.) The MDS Coordinators were instructed by the DON & ADON on 4/18/13 on accurately assessing residents and completing Care Plans according to RAI guidelines.

4.) DON/ADON will monitor for compliance through monthly audits for three (3) months then quarterly for six (6) months to ensure care plans reflect resident current conditions. Started 4-22-13. The results will be reviewed in the Quality Assurance Committee meeting quarterly and adjustments will be made as indicated.

Completion Date: 5/10/13
**VANCO MANOR NURSING AND REHABILITATION CENTER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**
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<td>F 279</td>
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<td>Interview on April 18, 2013, at 2:10 p.m. in the office of the Director of Nursing (DON) the DON confirmed the urinary catheter was not care planned.</td>
<td>F 279</td>
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<td>Review of a fax cover sheet to the Dental Service Provider dated October 17, 2012, revealed, &quot;...upper denture was found in the dryer with two chipped teeth that need to be repaired...&quot;</td>
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<td>Resident #130 was admitted to the facility on July 9, 2011, with diagnoses including Left Fractured Hip, Alzheimer's Dementia, and Hypertension.</td>
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<td>Medical record review of the care plan dated December 31, 2012, revealed no entry related to dental status.</td>
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<td>Interview on April 18, 2013, at 3:00 p.m., with the Director of Nursing (DON), in the DON's office, confirmed the care plan had not been developed for the dental status.</td>
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<td>Resident #26 was admitted to the facility on July 2, 2008, and readmitted on February 16, 2013, with diagnoses including Bipolar Disorder, Dysphagia (difficulty swallowing), and Depression.</td>
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<td>Medical record review of the Care Plan dated December 5, 2012 revealed no problem, goal, and/or interventions for dysphagia, diet waiver, or training instructions per speech therapy.</td>
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<td>Medical record review of an Informed Consent</td>
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Notification dated March 11, 2011, revealed "...Diet: Puree ...I do not wish for the above recommendations (puree diet) to be followed ..."

Medical record review of the Quality Assurance Training Contract dated February 3, 2012, revealed no straws were to be used.

Observation on April 17, 2013, at 7:40 a.m., in the resident's room, revealed the resident had a straw drinking milk from a carton.

Interview with a Certified Nurse Aide (CNA) on April 17, 2013, at 7:45 a.m., revealed the resident drinks liquids out of carton with a straw. Continued interview confirmed the resident does not require a straw if liquids are placed in a glass.

Interview with Minimum Data Set (MDS) Coordinator #2 on April 17, 2013, at 7:56 a.m., at the Nurse's Station, confirmed the resident had signed a diet waiver, and the resident was not to use a straw, liquids were to be placed in a glass, and the care plan had not been developed to reflect the resident's plan of care for Dysphagia.

Resident # 189 was admitted to the facility on December 9, 2011, with diagnoses including Alzheimer's Disease, Hypertension, Fractured Left Ankle, and Depression.

Medical record review of the Care Plan dated December 20, 2012, revealed no problem, goal, and/or interventions for dental problems or behaviors.

Medical record review of a Physician's Progress Note dated January 4, 2012, revealed
F 279  Continued From page 12

"...Increased verbal aggression...Psych consult for a further F/U (follow/up) and eval (evaluation)..."

Medical record review of a Physician's Progress Note dated February 3, 2012, revealed left lower gum line infection, positive for dental caries to left lower molar...Dental Consult..."

Interview with the MDS Nurse #1, on April 18, 2013, at 12:55 p.m., in the MDS Office, confirmed the facility failed to develop a Comprehensive Care Plan for dental issues and verbally aggressive behaviors for resident #189.

Resident # 13 was admitted to the facility on October 31, 2012, with diagnoses of Pneumothorax, Hypertension, Coronary Artery Disease, Ischemic Cardiomyopathy, Atrial Fibrillation, Asthma, Peripheral Vascular Disease, and Gastric Reflex Disease.

Medical record review of the resident's quarterly Minimum Data Set (MDS) dated February 3, 2012, indicated the resident was frequently incontinent (7 or more episodes of incontinence with at least one episode of continence). The admission MDS dated November 7, 2012, indicated the resident was always continent.

Medical record review of the resident's care plan dated November 12, 2012, revealed no documentation addressing the resident's incontinence.

Interview with the Director of Nursing (DON), in the DON's office on April 17, 2013, at 11:36 a.m., confirmed the resident's care plan for
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<td>incontinence had not been developed.</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>
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<td>SS=E</td>
<td>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.</td>
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<td>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</td>
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<td>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.</td>
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<td>Based on medical record review, observation, and interview, the facility failed to revise the Care Plan for seven (#27, #15, #189, #26, #130, #122, and #109) of thirty-three residents reviewed.</td>
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<td>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.</td>
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F 280

Continued From page 14

February 28, 2013, with diagnoses including Diabetes, Coronary Artery Disease, Hypertension, Gastroesophageal Reflux Disease, Diverticulosis, Alzheimer's Dementia, Hypothyroidism, Mixed Anxiety and Depression.

Medical record review of the admission Minimum Data Set (MDS) dated March 8, 2013, revealed a score of fifteen on the Brief interview for Mental Status (BIMS), indicating the resident was independent with daily decision making.

Medical record review of the Care Plan dated March 12, 2013, revealed "...Risk for poor hygiene as resident needs physical help in bathing...encourage independence with minor assistance, Assist with bathing/shower two times a week and sponge bathe on non shower days as needed...Resident likes to wear make up daily..."

Medical record review of the Care Plan dated March 12, 2013, revealed no documentation the resident had refused showers.

Observation on April 15, 2013, at 2:50 p.m., revealed a staff member offered to provide the resident a shower and the resident had refused, due to having the hair set.

Interview on April 17, 2013, at 1:50 p.m., with Certified Nursing Assistant (CNA) #6 (responsible for the resident's care) revealed the resident was scheduled to receive a shower on the evening shift. Continued interview revealed the resident had refused showers in the past.

Interview on April 17, 2013, at 1:55 p.m., with Licensed Practical Nurse (LPN) #3, in the

(X5) COMPLETION DATE

Corrective Action:

1.) MDS Coordinators reviewed and corrected the Care Plans for resident #27, #15, #26, #122, #130, and #109 to show accurate information on 4-18-13. Resident #189 had been discharged from the facility.

2.) The DON, ADON and MDS Coordinators will complete chart audits by 5/1/13 to ensure comprehensive assessments and care plans were completed correctly.

3.) The MDS Coordinators oversaw by the DON on 4/18/13 on accurately assessing residents and completing care plans using the RAI guidelines.

4.) The DON/ADON staring 4-22-13 will monitor care plans to ensure they reflect residents current conditions with monthly audits for three (3) months then quarterly for six (6) months. The results will be reviewed in the Quality Assurance Committee quarterly and adjustments will be made as indicated.

Completion Date: 5/10/13
F 280 Continued From page 15

A hallway, revealed the resident was scheduled to receive a shower on the evening shift, and the shower schedule was made by bed location, by the Director of Nursing or the Assistant Director of Nursing. Continued interview revealed the resident had refused showers at times due to not wanting to get the hair wet.

Interview on April 17, 2013, at 2:00 p.m., with the Director of Nursing, in the conference room, confirmed the Care Plan, dated March 12, 2013, had not been revised to include the resident's refusal of showers.

Resident #15 was admitted to the facility on March 23, 2013, and readmitted on April 9, 2013, with diagnoses including Basal Ganglia Stroke, Dehydration, and Dysphagia.

Medical record review of an Admission Minimum Data Set (MDS) dated March 30, 2013, revealed the resident required extensive assistance with all Activities of Daily Living, Incontinent of bowel and bladder, had a mechanically altered diet, and a swallowing disorder had been present.

Medical record review of the Care Plan dated April 4, 2013, revealed the care plan had no problems, goals, or interventions after the resident had been hospitalized for dehydration.

Medical record review of a History and Physical dated April 5, 2013, revealed the resident had been transferred to the emergency room with diagnosis Dehydration.

Medical record review of a Physician Telephone order dated April 10, 2013, revealed "...May have
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:

445460

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

04/19/2013

NAME OF PROVIDER OR SUPPLIER

VANCO MANOR NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

813 S DICKERSON RD

GOODLETTSVILLE, TN 37072

<table>
<thead>
<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID TAG</th>
<th>PROVIDERS 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 280</td>
<td>Continued From page 16 ice chips b/t (between meals)...&quot;</td>
<td>F 280</td>
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</tbody>
</table>

Medical record review of a speech training contract dated April 10, 2013, revealed "...May have ice chips b/t meals..."

Interview with Certified Nurse Aide (CNA) #4 on April 17, 2013, at 1:56 p.m., in the 300 hall, revealed the CNA had not been aware the resident could have ice chips.

Interview with CNA #7 on April 17, 2013, at 2:15 p.m., in the 300 hall, revealed the CNA had not been aware the resident could have ice chips.

Interview with LPN #2 and LPN #5 on April 117, 2013, at 2:16 p.m., in the 300 hall, revealed the resident had been allowed ice chips.

Interview with Speech Therapist on April 17, 2013, at 2:48 p.m., in the 300 nurse's station, revealed the speech contract had been completed by speech therapy and no documentation staff had been aware of the speech contract or the resident had been able to take ice chips.

Interview with the Director of Nursing on April 17, 2013, at 3:15 p.m., in the DON office, confirmed the care plan had not been updated after the resident had been hospitalized for dehydration.

Resident # 26 was admitted to the facility on July 2, 2008, readmitted on February 16, 2013, with diagnoses Bipolar Disorder, Dysphagia, and Depression.

Medical record review of the Comprehensive
F 280 Continued From page 17

Care Plan dated December 5, 2012, revealed the care plan had not been updated or revised to reflect the resident’s hospitalization for psychiatric treatment.

Medical record review of a Social Service Note dated January 26, 2013, revealed "...resident with increased agitation...referral...for inpatient psych (psychiatric) services...admitted to psych services..."

Medical record review of a Behavioral Medicine Progress Note dated March 19, 2013, revealed "...Patient is improving with an ongoing need for mood/behavior monitoring..."

Interview with the Minimum Data Set (MDS) Coordinator #1 on April 18, 2013, at 1:34 p.m., in the MDS Office, confirmed the Care Plan had not been updated to reflect the resident’s current behaviors or recent psychiatric admission.

Resident # 189 was admitted to the facility on December 9, 2011, with diagnoses including Alzheimer’s Disease, Hypertension, Fractured Left Ankle, and Depression.

Medical record review of the Quarterly Minimum Data Set (MDS) dated March 15, 2012, revealed the resident had been cognitively intact, the resident had verbal behavioral symptoms daily and the resident had severe pain frequently.

Medical record review of the Comprehensive Care Plan dated December 20, 2012, revealed the care plan had not been updated and/or revised to reflect the resident's frequent severe pain.
**F 280 Continued From page 18**

Interview with the MDS Coordinator on April 18, 2013, at 1:34 p.m., in the MDS office, confirmed the Interdisciplinary Care Plan had not been revised or updated to reflect the resident's current pain assessment.

Resident #130 was admitted to the facility on July 9, 2011, with diagnoses including Left Hip Fracture, Alzheimer's Dementia, and Hypertension.

Medical record review of a physician's progress note dated May 18, 2012, revealed the resident had a new pressure ulcer to the left heel.

Medical record review of the Weekly Wound Progress Note dated April 11, 2013, revealed, "(Left) heel pressure Date of Onset 5/17/12...stage IV..."

Medical record review of a physician's order dated December 5, 2012, revealed, "...Elevate left heel off bed (at) all times (waffle boot, multipodus boot, ect.)..."

Medical record review of a physician's order dated March 11, 2013, revealed, "...Roxanol (pain medication) 0.5 ml (milliliters) SL (sublingual) qd (everyday) prior to wound care pm (as needed)..."

Medical record review of a physician's progress note dated April 5, 2013, revealed, "...Roxanol pm (second to) acute pain (with) drag (dressing) (changes)...

Medical record review of the care plan dated April 12, 2012 and December 31, 2012, revealed no
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID PREFIX TAG</th>
<th>PROVIDERS PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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</thead>
<tbody>
<tr>
<td>F 280</td>
<td>Continued From page 19 documentation of the development of the pressure ulcer on the left heel, the boot on the left foot at all times, and the administration of pain medication with the dressing change to the left foot.</td>
<td>F 280</td>
<td>Cross-referenced to the appropriate deficiency</td>
<td>04/19/2013</td>
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Observation on April 17, 2013, at 3:30 p.m. with Licensed Practical Nurse #9 (LPN) revealed the resident lying on the bed with a boot on the left foot.

Interview on April 18, 2013, at 10:25 a.m. with the Director of Nursing (DON) in the DON's office, confirmed the care plan was not updated to include the boot.

Interview on April 18, 2013, at 4:00 p.m., with the DON, in the DON's office, confirmed the care plan had not been updated to reflect the pain with the wound care and the development of the pressure ulcer.

Resident #122 was admitted to the facility on October 6, 2011, with diagnoses including Dementia, Congestive Heart Failure, Anxiety, and Depression.

Medical record review of the Quarterly Minimum Data Set dated January 8, 2013, revealed the resident required one person physical assistance for bathing.

Medical record review of the care plan dated January 8, 2013, revealed no documentation to include bathing.

Interview on April 18, 2013, at 1:40 p.m., at the nursing station, with the Director of Nursing.
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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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<tbody>
<tr>
<td>F 280</td>
<td>Continued From page 20</td>
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<tr>
<td></td>
<td>confirmed the current care plan had not been revised to include bathing.</td>
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<td></td>
<td>Resident # 109 was admitted to the facility on June 6, 2012, with diagnoses of Rehabilitation Process,</td>
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<td></td>
<td>Alzheimer's Disease, Muscle Weakness, Abnormality of Gait, Hypertension, Pressure Ulcer, Unspecified Site,</td>
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<td>Diabetes Mellitus, and Hyperlipidemia.</td>
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<td>Medical record review of the resident's care plan originally dated July 12, 2012, revealed the resident had</td>
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<td>a stage IV sacral pressure ulcer, and no other pressure ulcers were addressed.</td>
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<td></td>
<td>Medical record review of the Nurse's admission assessment dated June 6, 2012, revealed the resident was</td>
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<tr>
<td></td>
<td>admitted with a stage IV sacral pressure ulcer, and bilateral stage II heel wounds.</td>
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<td></td>
<td>Interview with the wound care nurse, Licensed Practical Nurse (LPN) #6, in the 200 hall alcove, on April 18,</td>
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<td>2013, at 9:10 a.m., confirmed the bilateral heel wounds had resolved in July, 2012, and the sacral wound had</td>
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<td>resolved in August, 2012, and a stage II right lateral ankle pressure ulcer had developed in January, 2013,</td>
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<td></td>
<td>which was unstageable at present.</td>
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<td>Interview with the MDS Coordinator, LPN #2, on April 17, 2013, in the MDS Coordinator's office, at 1:52 p.m.,</td>
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<td>confirmed the sacral wound was the only wound listed on the care plan and the care plan had not been updated</td>
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<td>to reflect the bilateral heel, and the right lateral ankle wounds.</td>
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<td>Continued medical record review of the psychologist's monthly notes for January, 2013 through April, 2013 for</td>
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<td>resident #109 revealed the</td>
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<td>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</td>
<td>PROVIDER/SUPPLIER/CLINIC IDENTIFICATION NUMBER</td>
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<td>(X1) PROVIDER/SUPPLIER/CLINIC ID</td>
<td>445460</td>
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**NAME OF PROVIDER OR SUPPLIER**

VANCO MANOR NURSING AND REHABILITATION CENTER

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

613 S DICKERSON RD
GOODLETTSVILLE, TN 37072

<table>
<thead>
<tr>
<th>ID</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>F 280</td>
<td>Continued From page 21</td>
<td>resident had been taking zoloft 25 milligram one time daily for depression.</td>
<td>F 280</td>
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<td>Medical record review of the resident's care plan dated December 24, 2012, revealed the care plan did not address antidepressants, or address the side effects of Zoloft.</td>
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<td>Interview with the MDS Coordinator, LPN #2, on April 17, 2013, in the MDS Coordinator's office, at 2:00 p.m., confirmed the antidepressants had not been updated in the care plan.</td>
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<td>C/O #29634</td>
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<td>F 314</td>
<td>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</td>
<td>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview, the facility failed to ensure staff provided appropriate dressing care for one resident with a pressure sore(#130) of thirty-three residents reviewed.</td>
<td>F 314</td>
<td>SS=D</td>
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<td>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</td>
<td>Requirements: Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</td>
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The findings included:
Continued from page 22

Resident #130 was admitted to the facility on July 8, 2011, with diagnoses including Left Fractured Hip, Alzheimer's Dementia, and Hypertension.

Medical record review of the Weekly Wound Progress Note dated April 11, 2013, revealed the resident had a stage IV pressure ulcer on the left heel.

Review of the facility policy, "Hand Hygiene," revealed, "...hand hygiene must be accomplished... After contact with blood, body fluids or excretions... non-intact skin, wound dressings or other contaminated items..."

Observation on April 17, 2013, at 2:00 p.m., with Licensed Practical Nurse (LPN) #6 of a dressing change to the left heel revealed the following: LPN #6 obtained supplies from the wound care cart in the hall; set up a barrier on the overbed table; placed supplies on the barrier; washed the hands with soap and water and applied gloves; removed the soiled dressing from the left heel; and without removing the gloves and washing the hands LPN #6 cleaned the wound with Dakin's solution; removed the silver alginite from the wound on the left heel; irrigated the wound with Dakin's solution; removed the gloves and washed the hands with soap and water. Continued observation revealed LPN #6 applied gloves and applied silver alginite into the wound followed by a gauze dressing and tape; discarded supplies in a red biohazard bag; discarded the red biohazard bag in the trash on the side of the wound care cart; disposed of dirty linens in the linen cart in the hall; returned to the wound care cart and without washing the hands obtained a sanitizer pad from the wound care cart.

Corrective Action:
1.) Wound Care Nurse performed wound care on resident #130 on 4-22-13 and 4-24-13 with DON and ADON present to ensure compliance of appropriate dressing care and hand hygiene.
2.) Wound Care Nurse/ DON/ADON monitored admissions nurses unannounced during wound care on 5-17-13 and then again on 5-16-13 to ensure compliance.
3.) DON/ADON in-service Wound Care Nurse on 4/19/13 on "Hand Hygiene" during wound care procedures.
4.) DON/ADON will monitor Wound Care Nurses at unannounced intervals starting on 4-22-13 weekly for three (3) months to ensure compliance of appropriate procedure of dressing care and "Hand Hygiene."

Completion Date: 5/10/13
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

X1 PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:
445460

X2 MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

X3 DATE SURVEY COMPLETED
04/19/2013

NAME OF PROVIDER OR SUPPLIER
VANCO MANOR NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
513 S DICKERSON RD
GOODLETTSVILLE, TN 37072

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-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 314 Continued From page 23

Interview on April 17, 2013, at 2:15 p.m. with LPN #6, in the hall, confirmed LPN #6 did not wash the hands after disposing of the wound supplies and linens and prior to obtaining supplies from the wound care

F 315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, review of the facility policy, and interview, the facility failed to perform an accurate bladder assessment for one (#29) resident of thirty-three residents reviewed.
The findings included:

Resident #29 was admitted to the facility on August 26, 2008, with diagnoses including Fractured Upper Arm, Diabetes, and Hypertension.

Medical record review of the Significant Change in Status Minimum Data Set (MDS) dated November 1, 2012, revealed the resident was occasionally incontinent of urine.
F 315  Continued From page 24

Medical record review of the 30 day PPS (Prospective Payment System) MDS dated November 22, 2012, revealed the resident was frequently incontinent of urine.

Medical record review of the Quarterly MDS dated February 4, 2013, revealed the resident was frequently incontinent of urine.

Review of the facility policy, Bowel and Bladder Program, revealed, "The assessment must be reviewed quarterly...if changes are apparent, a complete assessment must be completed and a toileting plan initiated if indicated...if the patient is identified as incontinent you must initiate a 72 hour bowel and bladder record...determine the type of toileting program to initiate and indicate the urinary and bowel plan on the back of the 72 hour bowel and bladder record..."

Interview on April 17, 2013, at 10:00 a.m., in the conference room, with Licensed Practical Nurse (MDS) #2, confirmed a bladder assessment had not been completed to determine if the resident was appropriate for bladder training when the resident had a decline in urinary incontinence from November 1, 2012 to November 22, 2012.

F 319

SS=D

483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.

Corrective Action:

1.) Restorative Nurses performed Bladder assessment on 5-1-13 through 5-8-13 and set up appropriate bladder training program for resident #28.

2.) DON/ADON and MDS Coordinators audited comprehensive assessment on 6-1-13 through 5-3-13 to determine if other residents were affected by a decline in urinary incontinence and the need for bladder training. If so, the restorative nurses would initiate program.

3.) DON/ADON in-serviced MDS Coordinators on 5-1-13 on reporting to Restorative Nurse any decline in urinary incontinence so a bladder training program may be initiated.

4.) DON/ADON or Restorative Nurses will monitor comprehensive assessment for decline in bladder function starting on 5-1-13 then quarterly for six (6) months. The results will be reviewed in the Quality Assurance Committee quarterly and adjustments will be made as indicated.

Completion Date: 5/10/13
**F 319**

Continued From page 25

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, the facility failed to provide timely psychiatric services for one resident (#189) of thirty-three residents reviewed.

The findings included:

Resident #189 was admitted to the facility on December 9, 2011, with diagnoses including Alzheimer's Disease, Hypertension, Fractured Left Ankle, and Depression.

Medical record review of the Quarterly Minimum Data Set (MDS) dated March 15, 2012, revealed the resident was cognitively intact, had verbal behavioral symptoms daily and experienced severe pain frequently.

Medical record review of a Physician's Progress Note dated January 4, 2012, revealed "...Increased verbal aggression...Psych consult for a further F/U (follow-up) and eval..."

Medical record review of a Physician's Progress Note dated January 5, 2012, revealed "...Anxiety/Dementia...consult pending..."

Medical record review of a Physician's Order for Services dated February 20, 2012, revealed "...Resident yells often even when family is with...

Medical record review of a New Patient Behavioral Health Evaluation dated February 21, 2012, revealed "...Mental Status Exam...Speech: loud...Mood: Anxious...Panic..."
<table>
<thead>
<tr>
<th>F 319</th>
<th>Continued From page 26</th>
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<tbody>
<tr>
<td>Interview with the Director of Nursing (DON), on April 18, 2013, at 11:09 a.m., in the DON office, revealed a forty-six day delay in providing resident #189 with psychiatric services.</td>
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<table>
<thead>
<tr>
<th>F 327</th>
<th>483.25(j) SUFIFFICIENT FLUID TO MAINTAIN HYDRATION</th>
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<tbody>
<tr>
<td>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</td>
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</table>

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation, and interview the facility failed to provide ice chips for hydration for one resident (#15) of thirty-three residents reviewed.

The findings included:

Resident #15 was admitted on March 23, 2013, and readmitted to the facility on April 9, 2013, with diagnoses including Basal Ganglion Stroke, Dehydration, and Dysphagia.

Medical record review of an Admission Minimum Data Set (MDS) dated March 30, 2013, revealed the resident required extensive assistance with all Activities of Daily Living, Incontinent of bowel and bladder, had a mechanically altered diet, and a swallowing disorder had been present.

Medical record review of a Registered Dietician Nutrition Assessment dated March 23, 2013 revealed "...the resident has poor po (my mouth)"
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<tr>
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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>PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X6) COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 327</td>
<td>Continued From page 27 intake staff reports NP (Nurse Practitioner) aware of poor intake staff encouraging increase fluids and po intake...&quot;</td>
<td>F 327</td>
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<td>Medical record review of a Physician’s Telephone Order dated April 3, 2013, revealed &quot;...Patient allowed regular water/ice chips in between meals...&quot;</td>
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<td>Medical record review of a Nurse Progress Note dated April 5, 2013, revealed &quot;...new order for IV fluids received unable to stick MD notified instructed to notify family of Labs and resident does not take the thickened liquids so it is very unlikely PO intake will increase. Family request send to ER (emergency room)...&quot;</td>
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<td>Medical record review of a History and Physical dated April 5, 2013, revealed the resident had been transferred to the emergency room with diagnosis Dehydration.</td>
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<td>Medical record review of a Physician Telephone order dated April 10, 2013, revealed &quot;...May have ice chips b/t (between meals)...&quot;</td>
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<td>Medical record review of a speech training contract dated April 10, 2013, revealed &quot;...May have ice chips b/t meals...&quot;</td>
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<td>Interview with Certified Nurse Aide (CNA) #4 on April 17, 2013, at 1:56 p.m., in the 300 hall, revealed the CNA had not been aware the resident could have ice chips.</td>
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<td>Interview with CNA #7 on April 17, 2013, at 2:15 p.m., in the 300 hall, revealed the CNA had not been aware the resident could have ice chips.</td>
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<td>ID</td>
<td>TAG</td>
<td>F 327 Continued From page 28</td>
<td>F 327</td>
<td>F371</td>
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<tr>
<td>F371</td>
<td>483.36(f) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</td>
<td>Interview with LPN #2 and LPN #5 on April 117, 2013, at 2:16 p.m., in the 300 hall, revealed both were unaware the resident had been allowed ice chips. Interview with the Speech Therapist on April 17, 2013, at 2:48 p.m., in the 300 nurse's station, revealed the speech contract had been completed by speech therapy and no documentation staff had been aware of the speech contract or the resident had been able to take ice chips. Interview with the Director of Nursing on April 17, 2013, at 3:15 a.m., in the DON office, confirmed the speech therapist was supposed to have in-serviced all staff on the contracts. Continued interview revealed the facility failed to offer ice chips to the resident.</td>
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**F 371**

**483.36(f) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY**

The facility must:
1. Proceed from sources approved or considered satisfactory by Federal, State or local authorities; and
2. Store, prepare, distribute, and serve food under sanitary conditions.

This **REQUIREMENT** is not met as evidenced by:
Based on observation, review of the manufacturer's instructions, and interview, the...
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<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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</table>
| F 371 |     | Continued From page 29  
facility failed to ensure the dishmachine was at the proper temperature, failed to ensure the stove eyes were clean, and failed to distribute ice in a sanitary manner in one of two dining rooms.  
The findings included:  
Review of the manufacturer's instructions for the Dishmachine revealed, "...Low temperature dishmachines typically wash at 120 (degrees) F to 140 (degrees) F and rinse at the same temperatures..."  
Observation on April 15, 2013, at 10:00 a.m. with the Registered Dietician (RD), in the dietary department, revealed the dishmachine wash cycle was 118 degrees Fahrenheit, the rinse cycle was 120 degrees Fahrenheit, and the sanitizer was 50 PPM (Parts Per Million).  
Observation on April 15, 2013, at 10:10 a.m., in the dietary department, with the RD and the Dietary Manager, revealed a build up of grease on five out of six eyes on the stove.  
Interview on April 15, 2013, at 10:10 a.m., in the dietary department, with the RD, confirmed the dishmachine wash cycle was to be at 120 degrees and confirmed the stove needed to be cleaned.  
Review of the facility's policy Ice Storage Chests revealed "...To aid in preventing contamination of ice storage chests/containers or ice, all staff must implement the following precautions...Do not handle ice directly by hand..."  
Observation on April 15, 2013, at 11:51 a.m., revealed sixteen residents seated in the fine | | | | 2. On 4/16/2013, the Dietary Manager and RD conducted a kitchen and dining room inspection to ensure compliance with food storage, preparation, and distribution.  
3. 1.) On 4/22/2013, the RD in serviced the dietary staff on new cleaning schedule for the stovetop.  
2.) On 4/16/2013 through 4/22/2013, CNA staff was in serviced by the ADON on proper ice handling.  
4. The RD, Dietary Manager, and Nurse Management will monitor for compliance with ongoing inspections of the kitchen and dining rooms daily for three (3) months.  
Completion Date: 4/22/13 |
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
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| (XX3) DATE SURVEY COMPLETED | 04/19/2013 |

**NAME OF PROVIDER OR SUPPLIER**

**VANCO MANOR NURSING AND REHABILITATION CENTER**

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

613 S DICKERSON RD
GOODLETTSVILLE, TN 37072

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**ID PREFIX TAG**

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<th>F 371</th>
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<td></td>
<td>dining room. Continued observation revealed Certified Nursing Assistant (CNA) #4, used ice tongs with ungloved hands to obtain ice from the clean ice supply, and stored the ice tongs into the clean ice supply between serving the residents. Continued observation revealed the clean ice supply was located on a wheeled cart, and was moved from table to table to distribute ice and beverages.</td>
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**ID PREFIX TAG**

<table>
<thead>
<tr>
<th>F 411</th>
<th>483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS</th>
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**Requirement:**

The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.

**Corrective Action:**

1) The Social Worker followed up with resident (#182) and inquired if he would like to have dental consult and have dental services provided to him. Resident stated that he would like to have a routine dental visit. Dental service not provided due to resident discharged home prior to the dentist visit being able to occur.

2) On admission a dental assessment will be completed. All dental needs identified for routine or emergency services will be followed through with a referral to the dentist. All referrals will be completed by Social Service or a designee. Social Service will assist resident with making an appointment and by arranging transportation to and from the dentist office. Documentation for

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**ORM OMS-2387(02-98) Previous Versions Obsolete**

Event ID: VET11

Facility ID: TN1929

Page 31 of 48
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID</th>
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**NAME OF PROVIDER OR SUPPLIER**

VANCO MANOR NURSING AND REHABILITATION CENTER

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

813 S DICKERSON RD
GOODLETTSVILLE, TN 37072

<table>
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<tr>
<th>(X4) 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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<td>F 411</td>
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<td>Continued From page 31 by:</td>
<td>F 411</td>
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<td>all referrals to the dentist will be made in the resident's medical record.</td>
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<td>Based on medical record review, observation, and interview the facility failed to provide dental services to one resident (#182) receiving Medicare benefits of thirty-three residents reviewed.</td>
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<td>3) An In-service for all nursing staff to be completed by 5/15/13. Nursing will communicate all dental consults to Social Worker for routine/emergency dental services. Social Service will assist resident with making an appointment and by arranging transportation to and from the dentist office. Documentation for all referrals to the dentist will be made in the resident's medical record.</td>
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<td>The findings included:</td>
<td></td>
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<td>4) Social Worker will monitor through the quarterly Quality assurance program that all dental assessments resulting in a dental consult are followed up with a referral to see the dentist and documentation will be made in the resident's medical record.</td>
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<tr>
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<td></td>
<td>Resident #182 was admitted to the facility on March 23, 2013, with diagnosis including Cerebral Vascular Disease, Hypertension, and Seizure Disorder.</td>
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<td>Completion Date: 5/17/13</td>
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<td>Medical record review of the Admission Minimum Data Set (MDS) dated March 30, 2013, revealed no dental issues identified.</td>
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<td>Medical record review of the Registered Dietician Nutrition Assessment dated March 23, 2013, revealed the resident had own teeth and missing many.</td>
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<td>Observation and interview with Resident #182 on April 16, 2012, at 8:30 a.m., in the resident's room, revealed the resident had loose and missing teeth, and would like to see a dentist.</td>
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<td>Interview with the Social Service Director on April 17, 2013, at 5:40 p.m., in the front office, confirmed the facility failed to provide dental services.</td>
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**F 412 483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS**

The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent

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**Footnote:**

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**Event ID:** VET110111

**Facility ID:** TN1929

**If continuation sheet Page:** 32 of 48
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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**NAME OF PROVIDER OR SUPPLIER**

VANCO MANOR NURSING AND REHABILITATION CENTER

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

813 S DICKERSON RD  
GOODLETTSVILLE, TN 37072

**F 412** Continued From page 32

covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.

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

Based on medical record review, observation, and interview, the facility failed to provide dental services to two (#130, #189) of three residents receiving Medicaid benefits of thirty-three residents reviewed.

Resident #130 was admitted to the facility on July 9, 2011, with diagnoses including Left Fractured Hip, Alzheimer’s Dementia, and Hypertension.

Review of a fax cover sheet sent to the Dental Service Provider by the facility dated October 17, 2012, revealed, "...upper denture was found in the dryer with two chipped teeth that need to be repaired..."

Review of a fax sent to the facility by the Dental Service Provider dated April 18, 2013, revealed, "...Family never responded to request/signed a consent for dental treatment; we were unable to provide care without their consent..."

Interview with the Social Services Director on April 18, 2013, at 10:00 a.m., at the nursing station, confirmed the dental referral was sent on October 17, 2012, but no follow up was provided and the resident had not received dental services.

**F 412** Requirement:

The nursing facility must provide or obtain from outside resource, in accordance with 483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.

**Corrective Action:**

1) The Social Worker will contact the responsible party on behalf of resident (#130) to offer the opportunity to consent to have dental service provided to the resident to repair her upper denture. If responsible party is agreeable to dental services, consent will be obtained and dental services provided. Resident (#189) Discharged 3/31/13

2) Social Worker will interview NF resident’s 5-15-13 through 5-20-13 that are interview able to ensure that all NF residents in need of routine/emergency dental services may be obtained. D.O.N. or A.D.O.N will assess non-interview able residents 5-15-13 through 5-20-13 for the need of routine/emergency dental services. A dental consult will be obtained for all NF residents identified for the need of routine/emergency dental services. Social Worker will ensure Consent is obtained, appointment is made and transportation arranged if needed.
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| F 412     |     | Continued From page 33

Resident # 189 was admitted to the facility on December 9, 2011, with diagnoses including Alzheimer's Disease, Hypertension, Fractured Left Ankle, and Depression.

Medical record review of the Admission Minimum Date Set (MDS) dated December 16, 2011, revealed the resident had no dental issues identified.

Medical record review of a Physician's Progress Note dated February 3, 2012, revealed left lower gum line infection, positive for dental caries to left lower molar and a Dental Consult had been ordered.

Medical record review of a Physician's Progress Note dated March 13, 2012, revealed "...toothache/tooth pain...Dental consult..."

Medical record review revealed the resident had been transferred to an oral surgeon on March 15, 2013.

Interview with the Director of Nursing (DON), on April 18, 2013, at 12:55 p.m., in the DON office, confirmed the facility failed to provide dental services in a timely manner. Further interview confirmed a forty day delay in providing resident #189 with dental services.

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| F 412     |     | 3) Dental assessments will be completed quarterly through the MDS and care plan process. Any resident identified for the need of routine/emergency dental services, the Social Worker will ensure consent is obtained, appointment is made and transportation arranged if needed. Social Service will maintain documentation in the resident's medical record regarding dental service needs, referral, appointments and transportation arrangements.

4) Dental consents began 5-1-13 and by Social worker and will be reviewed quarterly for six (6) months through the quarterly quality assurance process.
Completion: 6/17/13

| F 425     | SS=B | 463.60(a)(b) PHARMACEUTICAL SVC-ACCURATE PROCEDURES, RPH |

Requirement:
The facility must provide routine and emergency drugs and biological to its residents, or obtain them under an agreement described in 483.75(b) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of the licensed nurse.
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**Continued From page 34**

§483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

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

Based on review of facility documentation, review of facility policy, and interview the facility failed to provide pharmacy services to four residents of thirty-three residents reviewed.

The findings included:

- Review of facility documentation Borrowed Medication Log revealed four narcotics had been borrowed from four residents to administer to other residents April 2-6, 2013.

- Review of facility policy Borrowing of Meds dated February 2013, revealed "...The practice must be limited to the exceptional occasion when a medication is needed and cannot be obtained from the pharmacy or the backup pharmacy..."
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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**DATE SURVEY COMPLETED**

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**NAME OF PROVIDER OR SUPPLIER**

**VANCO MANOR NURSING AND REHABILITATION CENTER**

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<th>(X3) COMPLETION DATE</th>
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<tr>
<td>F425</td>
<td>Continued From page 35</td>
<td>Interview with the Director of Nursing (DON), on April 18, 2013, at 9:13 a.m., in the DON Office, confirmed the backup pharmacy does not provide narcotics to the facility. Continued interview confirmed the facility borrowed four narcotics from residents to administer to other residents.</td>
<td>F425</td>
<td>obtained by referring to Night Box/Ergeon Box locked in Nursing Medication room. All problems will be reviewed in the Quality Assurance Committee quarterly and adjustments will be made as indicated.</td>
<td>04/19/2013</td>
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<td>F441</td>
<td>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</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; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted</td>
<td>F441</td>
<td>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</td>
<td>SS=E</td>
<td>Requirement: 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. (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</td>
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F 441 Continued From page 36
professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation, review of the facility policy, and interview, the facility failed to ensure infection control was maintained while lunch trays were being passed on one of three hallways, the facility failed to ensure infection control was maintained during a dressing change for one resident (#130), and the facility failed to ensure proper storage to prevent contamination of equipment for two residents (#190 and #13) of thirty-three residents reviewed.

The findings included:

Observation on April 15, 2013, at 12:15 p.m.
revealed Certified Nursing Assistant (CNA) #3
delivered the lunch tray to Resident #306,
adjusted the wheelchair pedal and moved the
overbed table closer to the resident. Continued
observation revealed CNA #3 then delivered
the lunch tray to Resident #314 without washing the
hands.

Review of the facility policy," Hand Hygiene",
revealed, "...Hand hygiene must be
accomplished: ...After contact with ...other
contaminated items ..."
Continued from page 37

Interview on April 18, 2013, at 1:40 p.m. with the Director of Nursing (DON), at the nursing station confirmed the hands are to be washed between serving meal trays to the residents. Resident #190 was admitted to the facility on April 4, 2013, with diagnoses of Acute Bowel Perforation, Acute Renal Failure, and Duodenal Ulcer.

During the initial tour on April 15, 2013, at 10:02 a.m., on the 200 hall, observation of the resident's room revealed nasal cannula tubing attached to an oxygen concentrator, and the nasal cannula was lying on the floor.

Interview with LPN #7, in the resident's room at 10:04 a.m., confirmed the tubing was on the floor.

Resident #13 was admitted to the facility on October 31, 2013, with diagnoses of Pneumothorax, Hypertension, Coronary Artery Disease, Ischemic Cardiomyopathy, Atrial Fibrillation, Asthma, Peripheral Vascular Disease, and Gastric Reflux Disease.

During the initial tour on the 200 hall, on April 15, 2013, at 10:12 a.m., the nebulizer mask was observed lying on the resident's bed, uncovered.

Interview with LPN #6, at 10:16 a.m., in the resident's room, confirmed the oxygen mask was not covered by a protective bag. "...and it was the facility's practice to cover the mask...."

Resident #130 was admitted to the facility on July 8, 2011, with diagnoses including Left Fractured
| F 441 | Continued From page 38  
Hepatitis B, Dementia, and Hypertension.  
Medical record review of the Weekly Wound 
Care Report dated April 11, 2013, revealed the 
resident had a stage II pressure ulcer on the left 
heel.  
Review of the facility policy, "Hand Hygiene," 
revealed, "...Hand hygiene must be 
accomplished...After contact with blood, body 
fluids or excretions...non-intact skin, wound 
dressings or other contaminated items...
Observation on April 17, 2013, at 2:00 p.m., with 
Licensed Practical Nurse (LPN) #6 of a dressing 
change to the left heel revealed the following: 
LPN #6 obtained supplies from the wound care 
cart in the hall; set up a barrier on the overbed 
table; placed supplies on the barrier; washed the 
hands with soap and water and applied gloves; 
removed the soiled dressing from the left heel; 
and without removing the gloves and washing the 
hands LPN #6 cleaned the wound with Dakin's 
solution; removed the silver alginite from the 
wrap on the left heel; irrigated the wound with 
Dakin's solution; removed the gloves and washed 
the hands with soap and water. Continued 
observation revealed LPN #6 applied gloves and 
and applied silver alginite into the wound followed 
by a gauze dressing and tape; discarded supplies in 
a red biohazard bag; discarded the red biohazard 
bag in the trash on the side of the wound care 
cart; disposed of dirty linens in the linen cart in 
the hall; returned to the wound care cart and 
without washing the hands obtained a sanitizer 
pad from the wound care cart.  
Interview on April 17, 2013, at 2:15 p.m. with LPN |
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| F441 | Continued From page 39
#6, in the hall, confirmed LPN #6 did not wash the hands after disposing of the wound supplies and linens and prior to obtaining supplies from the wound care cart.

Interview on April 17, 2013, at 2:30 p.m., with LPN #6, in the hall, confirmed LPN #6 did not wash the hands after removing the soiled dressing and prior to cleaning the wound. | F458 | 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION

Requirement:
The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Corrective Action:
1.) Maintenance Director removed two power strips from resident #100's room on 4/16/13.
2.) Maintenance Director made rounds to every room to make sure power strips were not being used for medical equipment. 4/16/13
3.) Maintenance Director will make weekly rounds to ensure facility is not using power strips for medical equipment.
4.) Administrator while making daily rounds will ensure compliance with regulation starting 5-1-13 daily for two (2) months. |

Completion Data: 5/15/13 | SS=D |
| F456 | 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION

The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. | SS=D |
| F505 | 483.75(i)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS

The facility must promptly notify the attending physician of the findings.

Completion Data: 5/15/13 | SS=D |
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This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, the facility failed to notify the Nurse Practitioner/Physician of laboratory results in a timely manner for one (#75) of thirty-three residents reviewed.

The findings included:

Resident #75 was admitted to the facility on February 8, 2008, with diagnoses including Osteoarthritis, Hypertension, and History of Falls.

Medical record review of a physician's order dated January 8, 2013, revealed a urinalysis with a culture and sensitivity was to be performed.

Medical record review of a laboratory report dated January 8, 2013, and received by the facility on January 11, 2013, revealed a positive urine culture with the causative organisms Enterococcus faecalis and alpha hemolytic strep species. Medical record review of the same laboratory report revealed susceptibility was not routinely performed on the alpha hemolytic species and the Enterococcus faecalis was susceptible to Ciprofloxacin (antibiotic). Medical record review of the same laboratory report revealed the report was initialed by the Nurse Practitioner on January 14, 2013.

Medical record review of a physician's order dated January 9, 2013, revealed the resident was to receive Bactrim (antibiotic) DS (doubly

| Requirements: |
| Corrective Action: |
| 1.) Resident #75 has been discharged from facility. |
| 2.) DON/ADON audited labs on 4-25-13 to ensure timely notification has occurred. |
| 3.) DON/ADON in-serviced all licensed nurses on 4-22-13 to contact physician/NP with culture and sensitivity reports as well as all abnormal results as they received for laboratory. |
| 4.) DON/ADON will monitor for compliance through audits of NP/MD report box Monday - Friday located at the nursing stations. Results of non-compliance will be reviewed in the Quality Assurance Committee quarterly and adjustments will be made as indicated. |

Completion Date: 5/10/13
**F 505**
Continued From page 41 strength) one tablet twice a day for seven days for Urinary Tract Infection (UTI).

Medical record review revealed no documentation the Nurse Practitioner or Physician was notified of the results of the positive urine culture and sensitivity, obtained by the facility on January 11, 2013, until January 14, 2013.

Medical record review of a physician’s order dated January 14, 2013, revealed the Bactrim was discontinued and a new order was received for Cipro 500 mg (milligrams) by mouth twice a day for seven days for treatment of the UTI.

Interview on April 19, 2013, at 8:10 a.m., with the Director of Nursing, in the conference room confirmed the three day delay in notifying the Nurse Practitioner/Physician of the positive urine culture and sensitivity, obtained by the facility on January 11, 2013, until January 14, 2013.

c/o #31133

F 514
483.75(1)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

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 assessment; the plan of care and services provided; the results of any preadmission screening conducted by the State;

F 514
483.75(1)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

Requirement:
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 assessment; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

Corrective Action:
1. A. Resident #4, #26, #71 behavior monitoring sheets have been reviewed and updated to reflect appropriate behavior monitoring. Resident #189 was discharged from facility.
2. B. Resident #75 has been discharged from facility.
3. C. Resident #27 preferences reviewed and shower times have been changed to accommodate resident choice of AM shower. Resident #115 has been discharged from facility.
4. D. DON/ADON to review all behavior monitoring sheets daily with MAR review to start 4-22-13 to ensure appropriate behaviors is documented on each resident.
| F 514 Continued From page 42 | F 514 | B. DON/ADON to review all records to ensure physician recapitulation orders are accurate starting 4-24-13 and then monthly with the new recaptulation for six (6) months.
C. DON/ADON in-service all licensed nurses 4-22-13 on SBAR (Situation, Background, Assessment or Appearance and Request) documentation 72 hours upon return from hospital. Nurses are to document all shower refusals in nursing notes.
3. A. DON/ADON in-service all licensed nurses on 4-22-13 for proper completion and usage of Behavior Monitoring Sheets.
B. DON/ADON to in-service all licensed nurses are to update all physician recapitulated orders to ensure accuracy.
C. DON/ADON in-service all license nurses on SBAR documentation as well as 72 hours documentation or hospital returns and shower refusals.
4.) DON/ADON will monitor for compliance daily MAR audits looking at behavioral monitor sheets and monthly with the new recapitations. All in-services completed by 4/22/13. The negative results will be reviewed in the Quality Assurance Committee meeting quarterly and adjustments will be made as indicated Completion Date: 5/10/13 |
F 514 Continued From page 43

January, February, and March 2013 revealed the resident was being monitored for side effects of Aricept (dementia), Namenda (dementia) Remeron (depression), and Trazodone (depression). Continued review of the Behavior Monitoring Flowsheet revealed the section on Targeted Behavior was not checked to indicate which particular behavior staff were supposed to monitor.

Interview with Licensed Practical Nurse (LPN) #3 on April 17, 2013, at 11:15 a.m., on the 100 hall, confirmed the Targeted Behaviors section of the Behavior Monitoring Flowsheet was not completed to indicate the types of behaviors which were being monitored.

Medical record review revealed resident #115 was admitted to facility on March 5, 2013, with diagnoses to include Congestive Heart Failure, Parkinson's, Hypertension, Osteopenia, and Uterine Cancer.

Review of physician's orders dated March 13, 2013, revealed "Send to ER for further evaluation..."

Review of nursing notes dated March 13, 2013 at 3:00 a.m., revealed "...O2 @ 81%, sent to ER..."

Review of the Physician/NP/PA Communication and Progress Note dated March 13, 2013 @ 6:00 a.m., revealed "...O2 sats 79% on room air. After O2 applied O2 sats 81%.

Review of nursing notes dated March 13, 2013, revealed resident returned to facility but there was no documentation of the status of the resident at
Continued From page 44

readmission. Review of nursing notes dated March 19, 2013, revealed resident was in hospital but no documentation of events leading up to the transfer and discharge from the facility. Continued review of nursing notes revealed no documentation the staff communicated with the physician regarding status of resident.

Review of physician orders dated March 19, 2013, revealed "...Send to ER to evaluate and treat for mental status change and decreased BP..."

Review of nursing notes and physician progress notes did not reveal the resident returned to the facility. Continued review revealed no discharge summary in the record.

Interview with the Director of Nursing on April 18, 2013, at 4:14 p.m., in the Director's office, confirmed there was no discharge note or discharge summary in the record.

Resident #75 was admitted to the facility on February 8, 2006, with diagnoses including Osteoarthritis, Hypertension, and History of Fall.

Medical record review of the nursing notes dated February 2, 2013, revealed "Sent to...hospital per Dr...orders d/t (due to) dehydration..."

Medical record review of a physician's order dated March 15, 2012, revealed the resident was to receive a Pureed diet with nectar thickened liquids.

Medical record review of the October 2012, through January 2013, physician's recapitulation
### DEPARTMENT OF HEALTH AND HUMAN SERVICES
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

<table>
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<th>(X1) PROVIDER/SUPPLIER/CWA IDENTIFICATION NUMBER</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<td>445460</td>
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**NAME OF PROVIDER OR SUPPLIER**

VANCO MANOR NURSING AND REHABILITATION CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**
813 S DICKERSON RD
GOODLETTSVILLE, TN 37072

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<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tr>
<td>F 514</td>
<td>Continued From page 45</td>
<td>orders revealed &quot;...Magic cup with all meals, encourage by mouth fluids...Dysphagia II Ground: No bread or fruit allowed, nectar thick liquids...&quot;</td>
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Interview on April 18, 2013, at 8:30 a.m., with the Registered Dietician and the Assistant Director of Nursing, in the conference room, revealed the resident had received the pureed diet as ordered. Continued interview confirmed the physician's recaptulation orders were not accurate.

Resident #27 was admitted to the facility on February 28, 2013, with diagnoses including Diabetes, Coronary Artery Disease, Hypertension, Gastroesophageal Reflux Disease, Diverticulitis, Alzheimer's Dementia, Hypothyroidism, Mixed Anxiety and Depression.

Interview on April 16, 2013, at 2:47 p.m., with the resident revealed the resident had not had a shower in over a week.

Medical record review revealed no documentation of when the resident had received a shower.

Interview on April 17, 2013, at 2:00 p.m., with the Director of Nursing, in the conference room, confirmed there was no documentation in the medical record of when the resident had received a shower.

Resident #26 was admitted to the facility on July 2, 2008, and readmitted on February 16, 2013, with diagnoses Bipolar Disorder, Dysphagia, and Depression.

Medical record review of a Social Service Note dated January 28, 2013, revealed "...resident with..."
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**Continued From page 46**

increased agitation...referral...for inpatient psych (psychiatric) services...admitted to psych services...

Medical record review of Behavior Monitoring Flowsheets dated January 2013, through April 2013, revealed "...Targeted Behavior: (check appropriate category of behavior)..." Continued review revealed no targeted behaviors checked.

Interview with the Director of Nursing (DON), in the DON Office, on April 18, 2013, at 1:55 p.m., confirmed the facility failed to indicate the behavior monitored on the Behavior Monitoring Flowsheets from January 2013, through April 17, 2013.

Resident # 189 was admitted to the facility on December 9, 2011, with diagnoses including Alzheimer's Disease, Hypertension, Fractured Left Ankle, and Depression.

Medical record review of the Quarterly Minimum Data Set (MDS) dated March 15, 2012, revealed the resident had been cognitively intact, the resident had verbal behavioral symptoms daily and the resident had severe pain frequently.

Medical record review of a Physician's Progress Note dated January 4, 2012, revealed "...Increased verbal aggression...Psych consult for a further F/U (follow-up) and eval..."

Medical record review of Behavior Monitoring Flowsheets dated December 2011, through March 2012, revealed "...Targeted Behavior: (check appropriate category of behavior)..."

Continued review revealed no targeted behaviors...
Interview with the Director of Nursing (DON), in the DON Office, on April 18, 2013, at 1:55 p.m., confirmed the facility failed to indicate the behavior monitored on the Behavior Monitoring Flowsheets from December 2011, through March 2012.

c/o #31133

c/o #29634