Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 29984, Baltimore, MD 21212, and to the Office of Management and Budget, Paperwork Reduction Project (0938-0960), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number
445451

(Y2) Multiple Construction
A. Building
B. Wing

(Y3) Date of Revisit
3/14/2014

Name of Facility
DECATHUR COUNTY HEALTH CARE AND REHABILITATION, INC

Street Address, City, State, Zip Code
726 KENTUCKY AVE
PARSONS, TN 38363

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-567 (prefix codes shown to the left of each requirement on the survey report form).

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Reviewed By: 
Reviewed By: 
Date: 3/7/14
Signature of Surveyor: 
Date: 3/17/14

State Agency:
Reviewed By: 
Date: 3/17/14
Signature of Surveyor:
Date: 3/17/14

Followup to Survey Completed on: 2/12/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-567) Sent to the Facility? YES NO
### Post-Certification Revisit Report

**Department of Health and Human Services**  
**Centers for Medicare & Medicaid Services**

- **(Y1) Provider / Supplier / CLIA / Identification Number**: 445451
- **(Y2) Multiple Construction**
  - A. Building 01 - MAIN BUILDING 01
  - B. Wing
- **(Y3) Date of Revisit**: 3/14/2014

**Name of Facility**

**DECATURE COUNTY HEALTH CARE AND REHABILITATION, INC.**

**Street Address, City, State, Zip Code**

726 KENTUCKY AVE
PARSONS, TN 38363

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

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**Reviewed By**:  
- **State Agency**: [Signature] Ricky More  
- **Date**: 3/17/14
- **Signature of Surveyor**: [Signature] Ricky More  
- **Date**: 3/17/14

**Followup to Survey Completed on**: 2/10/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES NO**
State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number
TN2001

(Y2) Multiple Construction
A. Building
B. Wing
01 - MAIN BUILDING 01

(Y3) Date of Revisit
3/14/2014

Name of Facility
DECATUR COUNTY HEALTH CARE AND REHABILITATION, INC

Street Address, City, State, Zip Code
726 KENTUCKY AVE
PARSONS, TN 38363

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Reviewed By
State Agency
Reviewed By
Reviewed By
CMS RO

Followup to Survey Completed on: 2/10/2014

Date: 3/17/14
Signature of Surveyor: Ricky Bore

Date: 3/17/14
Signature of Surveyor:

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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<tr>
<th>ID</th>
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<tr>
<td>F 280</td>
<td>483.20(d)(3), 483.10(k)(2) Right to Participate Planning Care-Revise CP SS=D</td>
<td>Requirement: 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.</td>
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</table>

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

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review, observation and interview, it was determined the facility failed to update the care plan for 1 of 21 (Resident #145) sampled residents included in the stage 2 review.

The findings included:

- Review of the facility "Care Plans" policy documented, "Care planning is an essential part of healthcare providing a "road map" of sorts, to guide all who are involved with the patient's care... The care plan process must begin upon..."

LAWYERY DIRECTIONS OR PROVIDER / SUPPLIER REPRESENTATIVE'S SIGNATURE: [Signature]

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

**(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:**
445451

**STREET ADDRESS, CITY, STATE, ZIP CODE**
726 KENTUCKY AVE
PARSONS, TN 38363

<table>
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<tr>
<th>ID PREFIX TAG</th>
<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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<td>F 280</td>
<td>Continued From page 1 admission into the facility and be fluid and changeable representing the patient's status until the patient is discharged from the facility or is deceased...” Medical record review for Resident #145 documented an admission date of 11/1/13 with diagnoses of Aspiration Pneumonia, Anemia, Parkinson's Dementia, Advanced Age and Frailty. A physician order dated 1/30/14 documented, &quot;...Jevity 1.5 cal [calories] AT 60 cc/HR [cubic centimeter per hour] WITH 25 cc/HR H2O AUTO FLUSH...&quot; The current care plan was not revised to include the most current dietary/nutritional feedings and water flushes per physician orders. Observations in Resident #145's room on 2/11/14 at 10:40 AM, revealed Resident #145 receiving Jevity 1.5 at 60 cc/hr. Observations in the 200 hall on 2/11/14 at 3:45 PM, revealed Resident #145 being pushed down the hall with the feeding pump with Jevity 1.5 infusing at 60 cc/hr. During an interview in the conference room on 2/12/14 at 10:42 AM, the Minimum Data Set (MDS) nurse was asked where the feeding information was on the care plan. The MDS nurse stated, &quot;...I didn't see it on there...&quot;</td>
<td>F 280</td>
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<td>02/12/2014</td>
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<td>F 441</td>
<td>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</td>
<td>F 441</td>
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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.
### F 441: Continued From page 2

(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 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 observation and interview, it was determined the facility failed to ensure practices to prevent the potential spread of infection or cross contamination were maintained when 1 of 5 (Nurse #3) nurses failed to wash hands or use a
Continued From page 3
different tissue between instilling eye drops or clean the stethoscope prior to checking placement of a Percutaneous Endoscopy Gastrostomy (PEG) tube.
The findings included:
Observations during medication administration in Resident #103's room on 2/11/14 at 11:20 AM, Nurse #3 washed her hands, put on gloves and instilled eye drops into a resident's left eye and then proceeded to instill eye drops into the resident's right eye. Nurse #3 did not wash her hands, change gloves or use a clean tissue between instillation of the eye drops from the left eye to the right eye.
Observations during medication administration in Resident #145's room on 2/11/14 at 11:35 AM, Nurse #3 washed her hands, put on gloves, removed the stethoscope from around her neck and then checked placement of the PEG tube. Nurse #3 did not sanitize the stethoscope prior to checking PEG tube placement.
During an interview in the Director of Nursing's (DON) office on 1/12/14 at 9:00 AM, the DON was asked what is the procedure for administering eye drops. The DON stated, "...We would wash our hands and glove, take a tissue to the lower lid, administer drop, re-wash hands and don new gloves, obtain a new tissue and administer new drop..." The DON was asked what would she expect her staff to do with a stethoscope that has been hanging around the nurse's neck before checking PEG tube placement. The DON stated, "Stethoscope should be cleaned prior to auscultation and aspiration...we use sanitizing wipes as well as bleach wipes..."
SS-D

Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:

a) the required manual fire alarm system;
b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and
c) the automatic sprinkler system, if installed.

19.2.2.2.6, 7.2.1.8.2

This STANDARD is not met as evidenced by:
Based on observation, it was determined the facility failed to maintain 2 of 6 corridor fire doors to close properly.

The findings included:
1. Observation of the fire doors by the beauty shop on 2/10/14 at 9:50 AM, revealed the door would not latch when manually released by the maintenance supervisor.
2. Observation of the fire doors by resident room 303 on 2/10/14 at 2:00 PM, revealed the door would not latch when released by activation of the fire alarm system.

K 021
SS-D

Requirement:
The facility will ensure any door in an exit passageway, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:

a) the required manual fire alarm system;
b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and
c) the automatic sprinkler system, if installed.

19.2.2.2.6, 7.2.1.8.2

Corrective Action:
1. a) The closing/latching system on the fire doors by the beauty shop will be replaced/repair by the maintenance department on or before 3/21/14 to ensure the latches when manually released.
b) The closing/latching system on the fire doors by resident room 303 will be replaced/repair by the maintenance department on or before 3/12/14 to ensure the latches when released by the activation of the fire alarm system.
2. On 2-11-14, the maintenance department audited all fire doors to ensure proper latching upon manual release, and also upon activation of the fire alarm system.
3. The maintenance department was inspected on 2-21-14, by the administrator, regarding proper latching of fire doors upon manual release and also upon activation of the fire alarm system.
4. The administrator, maintenance department and/or other designee will monitor for compliance through routine monthly facility rounds to ensure fire doors latch upon manual release and also upon activation of the fire alarm system, and report findings to the QA&A committee quarterly.

3-12-14
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<td>K021</td>
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<td>K054</td>
<td>NFPA 101 Life Safety Code Standard SS=D All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3</td>
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<tr>
<td>K054</td>
<td>Requirement: The facility will ensure all required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications.</td>
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<td>K052</td>
<td>Corrective Action: 1. On or before 3-12-14, the contracted fire alarm monitoring company will install a smoke detector in the electrical room inside the rehabilitation department. 2. The maintenance department conducted facility rounds on 2-20-14 to ensure proper placement of smoke detectors throughout the facility. 3. The maintenance department was inspected on 2-21-14, by the administrator, regarding proper placement of smoke detectors throughout the facility. 4. The administrator, maintenance department and/or other designee will monitor for compliance through routine monthly facility rounds to ensure proper placement of smoke detectors, and report findings to the Q&amp;A committee quarterly.</td>
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K 062: Continued From page 2

This STANDARD is not met as evidenced by:
NFPA 25, 1998 edition
5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development.

5-5.5.2.2
Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures.

This STANDARD is not met as evidenced by:
Based on observation, it was determined the facility failed to maintain clearance between all sprinkler heads and obstructions.

The findings included:
Observation of the 400 hall fire doors beside the nurses station on 2/10/14 at 10:20 AM, revealed the sprinkler head coverage was obstructed with a combination exit and emergency light fixture.

This finding was verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 2/10/14.

K 104
NFPA 101 LIFE SAFETY CODE STANDARD
SS=I
Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.
K 104  Continued From page 3

This STANDARD is not met as evidenced by:
Based on observation, it was determined the facility failed to maintain fire walls.

The findings included:

1. Observation above the fire smoke doors by the 500 hall nurses' station on 2/10/14 at 12:15 PM, revealed 2 penetrations around the electrical conduit.

2. Observation above the fire doors at the 4 hour separation into the 300-400 wing on 2/10/14 at 1:00 PM, revealed penetrations in the corner seam where the smoke walls meet the 4 hour wall hour.

3. Observation above the 1 hour fire doors by resident room 505 on 2/10/14 at 1:15 PM, revealed unknown substance sealing two 2 inch conduits and a corner penetration where the smoke wall meets the 1 hour fire wall.

The finding was verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 2/10/14.

K 104

554-D

Requirement:
The facility will ensure penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.

Corrective Action:
1. a) The penetrations around the electrical conduit above the fire smoke doors by the 500 hall nurse's station were properly repaired on 2-28-14 by the maintenance department.
   b) The penetrations in the corner seam where the smoke wall meet the 4 hour wall above the fire doors at the 4 hour separation into the 300-400 wings were properly repaired on 2-28-14 by the maintenance department.
   c) The two 2 inch conduits and a corner penetration where the smoke wall meets the 1 hour fire wall above the 1 hour fire doors by resident room 505 were properly repaired on 2-28-14 by the maintenance department.

2. The maintenance department conducted facility rounds on 2-24-14 to ensure penetrations were maintained appropriately throughout the facility.

3. The maintenance department was interviewed on 2-21-14, by the administrator, regarding proper maintenance of penetrations throughout the facility.

4. The administrator, maintenance department and/or other designee will monitor for compliance through routine monthly facility rounds to ensure proper maintenance of penetrations, and report findings to the QA&A committee quarterly.

3-12-14
N1410 1200-8-6-.14(2)(a)5.(ii) Disaster Preparedness

(2) Physical Facility and Community Emergency Plans.

(a) Physical Facility (Internal Situations).

5. Each of the following disaster preparedness plans shall be conducted annually prior to the month listed in the plan. Drills are for the purpose of educating staff, resource determination, testing personnel safety provisions and communications with other facilities and community agencies. Records which document and evaluate these drills must be maintained for at least three (3) years.

(i) External disaster procedures plan (for tornado, flood, earthquake), to be exercised prior to March, shall include:

(I) Staff duties by department and job assignment; and,

(ii) Evacuation procedures.

This Rule is not met as evidenced by:

1200-6-06-14

5. Each of the following disaster preparedness plans shall be conducted annually prior to the month listed in the plan. Drills are for the purpose of educating staff, resource determination, testing personnel safety provisions and communications with other facilities and community agencies. Records which document and evaluate these drills must be maintained for at least three (3) years.

(ii) External disaster procedures plan (for tornado, flood, earthquake), to be exercised prior to March, shall include:
Continued From page 1

(i) Staff duties by department and job assignment; and,
(ii) Evacuation procedures.
(iii) Bomb Threat Procedures Plan, to be exercised at any time during the year:

This Rule is not met as evidenced by:

Based on document review, it was determined the facility failed to conduct annual disaster drills for all staff.

The findings included:

During the document review in the 300 dining room on 2/10/14 at 10:30 AM, the facility failed to provide evaluations of a flood, earthquake and bomb threat drills for all staff on all shifts.

These findings were verified by the maintenance supervisor and acknowledged by the Administrator during the exit conference on 2/10/14.