<table>
<thead>
<tr>
<th>F 278</th>
<th>483.20(g) - (i) RESIDENT ASSESSMENT</th>
<th>F 278: November 7th, 2009</th>
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</thead>
<tbody>
<tr>
<td>SS=D</td>
<td>The assessment must accurately reflect the resident's status.</td>
<td>1. RI #12 MDS has been corrected to accurately reflect residents status.</td>
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<td>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</td>
<td>2. Residents who triggered for falls on the QI/QM report have the potential to be affected by the alleged deficient practice.</td>
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<td>A registered nurse must sign and certify that the assessment is completed.</td>
<td>3. Resident Care Management Director or designee to audit all residents that trigger for falls on QI/QM report for the next 90 days to ensure all are accurately coded on their MDS.</td>
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<td>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</td>
<td>MDS staff and Director of Nursing to be re-educated by the Regional Care Management Coordinator on proper coding of the MDS assessments.</td>
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<td>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.</td>
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<td>Clinical disagreement does not constitute a material and false statement.</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on medical record review and interviews, it was determined the facility failed to ensure the Minimum Data Set (MDS) revealed the correct assessment for falls for 1 of 24 (Resident #12) sampled residents.</td>
<td>The findings included:</td>
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<tr>
<th>VORATORY DIRECTOR'S OR PROVIDER/ SUPPLIER REPRESENTATIVE'S SIGNATURE</th>
<th>TITLE</th>
<th>(XS) DATE</th>
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Medical record review for Resident #12 documented an admission date of 6/8/09 with diagnoses of Chronic Obstructive Pulmonary Disease, Hypertension, Dementia, Abdominal Aortic Aneurysm and Osteoporosis. Review of the full MDS assessment form with an assessment reference date of 7/30/09 for "SECTION J. 4 ACCIDENTS a. Fell in past 30 days" was coded for falls.

During an interview in the conference room on 10/7/09 at 10:15 AM, the Director of Nursing stated, "She [Resident #12] has not had any falls here that I am aware of..."

During an interview in the conference room on 10/7/09 at 12:30 PM, the MDS Coordinator stated, "The fall was marked in error... she [Resident #12] has had no falls here..."

F 280 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

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

F 278

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

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

280: November 7th, 2009

1. RI# 1 care plan was updated and reflected current status
2. RI# 8 care plan was updated and now reflects current hospice status and psychiatric services.
3. RI# 14 care plan was updated and now reflects current medications and interventions for wound treatments.
and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and an interview, it was determined the facility failed to revise the resident care plan for psychiatric services, fall interventions or medications for 3 of 24 (Residents #1, 8 and 14) sampled residents.

The findings included:

1. Medical record review for Resident #1 documented an admission date of 6/24/09 with diagnoses of Chronic Obstructive Pulmonary Disease, Hypertension, Alzheimer's Disease, Parkinson's Disease, Osteoarthritis, Hiatal Hernia, Benign Prostate Hypertrophy and Diabetes Mellitus. Review of the change of condition forms documented Resident #1 sustained a fall on 6/25/09, 6/26/09, 6/27/09, 7/7/09, 7/15/09, 8/5/09, 8/15/09 and two falls on 9/17/09. Review of the care plan dated 7/8/09 and reviewed on 10/1/09 documented no new interventions for the fall sustained on 7/7/09.

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

2. Medical record review for Resident #8 documented an admission date of 9/17/03 with

- Residents with the potential to be affected by the alleged deficient practice
  Residents that have had a fall, hospice residents and/or residents with wounds.

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

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

- Director of Nursing/designee will re-educate license staff on updating care plans
F 280 Continued From page 3

diagnoses of Senile Dementia, Psychosis, Hypertension and Dysphagia. Review of the psychiatric progress notes and a physician's telephone order dated 9/17/09 documented, "D/C [discontinue] psych [psychiatric] services dt [due to] hospice in place." Review of the care plan dated 4/28/09 and reviewed on 7/25/09 documented, "Followed by [name of contracted psychiatric services]." The care plan did not reflect Resident #8's psychiatric services had been discontinued.


F 309 483.25 QUALITY OF CARE

SS=D

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to provide a plan

immediately at the time of an event.

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

Action team to review residents with wounds weekly to ensure updates are reflected in care plans.

All new hospice residents will be brought to morning meeting for review of care plan updates following their admission to hospice.

4. Director of Nursing /designee will report any identified trends to Quality Assurance Committee monthly X 3.
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CWA IDENTIFICATION NUMBER:

445267

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
10/07/2009

NAME OF PROVIDER OR SUPPLIER
GREENHILLS HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
3339 HILLSBORO CIRCLE
NASHVILLE, TN 37215

(X4) [ID] SUMMARY STATEMENT OF DEFICIENCIES
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)

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of care for coordination of hospice services for 1
of 3 (Resident #8) sampled residents receiving
hospice care.

The findings included:

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

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

F 323
SS=0

483.25(h) ACCIDENTS AND SUPERVISION

F 323

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

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it
was determined the facility failed to implement
new interventions after falls for 1 of 9 (Residents
#1) sampled residents with multiple falls.

The findings included:

F 309
309: November 7th, 2009

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

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

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

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

a. 6/25/09 at 9:30 PM, "...found lying in front of w/c [wheelchair]...[no] injury noted..."
b. 6/26/09 at 1:00 PM, "...Observed Resident lying down on the floor...Small skin Tear noted..."
c. 6/27/09 at 2:00 PM, "...Observed, Resident lying down on floor...[no c/o [complaint] of pain or discomfort..."
d. 7/17/09 at 7:00 PM, "...slipped off bed onto buttock..." skin tear to right elbow.
e. 7/15/09 at 8:00 AM, "...Observed Resident lying on the floor...[no] injury noted..."
f. 8/5/09 at 1:00 PM, "...Observed Resident lying on the floor beside Bed...[no]...[injury noted...]"
g. 8/15/09 at 7:45 PM, "...Resident was observed on the floor, supine, near the door..."
h. 9/17/09 at 2:30 PM, "...Resident was sitting in a small w/c...he leaned back and fell to the floor...Note hematoma to the back of the head..."
i. 9/18/09 at 4:10 PM, "...Pt [patient] was placed in a regular w/c...Pt was able to tip over regular w/c in dayroom. Pt hit head again..."

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

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

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

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

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

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

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

F 328 493.25(k) SPECIAL NEEDS

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

This REQUIREMENT is not met as evidenced by:

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

The findings included:


F 328: November 7th, 2009

1. RI#11 is currently receiving O2 accurately according to their physician's orders. RI#20 is currently receiving O2 accurately according to their physician's orders.

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

3. Director of Nursing/designee to educate staff on how to correctly set liters per minute on the Oxygen concentrators. Licensed nurse to document every shift on the treatment administration record for residents with O2 ordered, indicating...
F 328  Continued from page 7

Observations in Resident #11's room on 10/5/09 at 6:30 AM and 1:35 PM and on 10/7/09 at 8:30 AM, revealed Resident #11 receiving O2 per nasal cannula at 2L/min. On 10/5/09 at 9:50 AM, the Unit Manager for the 3rd floor went into Resident #11's room with the surveyor and verified Resident #11's O2 was set at 2L/min. The Unit Manager changed Resident #11's O2 to the correct rate of 3L/min.

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

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

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

F 328  current physician orders are being followed appropriately.

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

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