<table>
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<th>F 167</th>
<th>SS=C</th>
<th>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</th>
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| This resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure that the survey results were readily accessible to all residents without requesting to see the results.

The findings included:
During an interview in the room of the resident council president (Resident #9) on 8/27/12 at 5:30 PM, the council president stated she was unaware of the location of the survey results.

Observations on 8/27/12 following the interview at 5:30 PM revealed the survey results were found on top of the fish tank in a labeled book, but not accessible to wheelchair residents.

Observations on 8/29/12 at 9:00 AM, revealed a sign posted in the hallway across from the main lobby that documented "Survey results posted: End table main lobby, Nurses Station #1, Outside Main Dining Room". Observation at that
**F 167**
Continued From page 1
time revealed the survey results were placed on the top of the fish tank out of reach of a wheelchair bound resident. There was no evidence of the survey results at nurses station #1. There was a plastic holder on the wall across from the Birds Nest Cafe (main dining room) but there was nothing in the holder.

On 8/30/12 at 10:00 AM, the surveyor took the administrator to the front lobby to see the posting of the survey results. The administrator stated, "The [survey] results are on the fish tank." The administrator was asked if a resident in a wheelchair could reach the survey results located on the fish tank. The administrator placed the book containing the survey results on the coffee table and stated, "now they can." The surveyor accompanied the administrator to nurses station #1. The administrator went inside the locked nurses' station and opened a cabinet where the survey results were found. The administrator was asked how the residents would obtain the results to review when they are locked up inside the nurses' station. The administrator stated, "They [survey results] should be in there."

**F 241**
483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

**F 241**

All findings will then be reported to the facility's Quality Assurance (QA) committee for review and further recommendations. The QA committee consists of the Administrator, Director of Nursing, Medical Director, Assistant Director of Nursing, Dietary Manager, Social Services Director and Activities Director.

No adverse effects were noted as a result of this deficient practice. All residents have the potential to be affected by this deficient practice.

On 9/13/12 facility updated its policy regarding "Quality of Life-Dignity" to state that Staff will knock on resident door and request permission to enter residents' room, and if no response is heard.
**F 241** Continued From page 2

This REQUIREMENT is not met as evidenced by:

Based on policy review, observation and interview, it was determined the facility failed to ensure resident dignity and respect for 1 of 26 (Resident#24) sampled residents included in the stage 2 review.

The findings included:

Review of the facility's "Quality of Life-Dignity" policy documented, "Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality... 6. Residents' private space and property shall be respected at all times. a. Staff will knock and request permission before entering residents' room."

During an interview in Resident #24's room on 8/28/12 at 9:30 AM, two random staff members knocked on the closed resident door and then entered the room without asking or waiting for permission to enter.

During an interview in the administrator's office conducted on 8/30/12 at 8:30 AM, the Director of Nursing (DON) was asked what was expected of staff prior to entering a resident's room. The DON stated, "I expect staff to knock on the doors and wait for a response, if they don't get a response they should crack the door and speak to the resident."

**F 253** 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES

The facility must provide housekeeping and maintenance services necessary to maintain a

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<tr>
<td>F 241</td>
<td>from resident staff will knock on door again and then open door to ensure that resident is okay. The administrator will in-service the staff on 9/19/12 and 9/26/12 regarding resident dignity and respect and ensuring that staff will knock and request permission before entering a resident's room. Maintaining dignity and respect will be monitored by the Director of Nursing or designee by conducting random observations of staff entering resident's rooms weekly for four weeks, monthly for two months and randomly thereafter. All findings will then be reported to the facility's Quality Assurance (QA) committee for review and further recommendations. The QA committee consists of the Administrator, Director of Nursing, Medical Director, Assistant Director of Nursing, Dietary Manager, Social Services Director and Activities Director.</td>
<td>9/30/12</td>
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<td>F 253</td>
<td>7253</td>
<td>No adverse effects were noted as a result of this deficient practice. All residents have the potential to be affected by this deficient practice.</td>
<td>9/30/12</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<tr>
<td>F 253</td>
<td>483.70(d)(1)(iv)-(v)</td>
<td>BEDROOMS ASSURE FULL VISUAL PRIVACY</td>
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**NAME OF PROVIDER OR SUPPLIER**

DOUGLAS NURSING HOME

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

2084 W MAIN ST
MILAN, TN 38358

**DATE SURVEY COMPLETED**

08/30/2012

**ID PREFIX TAG**

445434

**SUMMARY STATEMENT OF DEFICIENCIES**

- **F 253**: Continued From page 3 sanitary, orderly, and comfortable interior.

This **REQUIREMENT** is not met as evidenced by:
- Based on policy review, observation and interview, it was determined the facility failed to maintain a clean environment for 9 of 32 (Rooms 400, 402, 403, 404, 406, 407, 408, 409, and 410) resident rooms observed during the stage 1 and stage 2 survey.

The findings included:
- Review of the facility's "Wall/Baseboard Washing" policy documented. "Steps to Do Job-Concrete Walls / Baseboard-Cleaning solution prepared, - Wet wall with clear water-Using sponge/cloth apply solution to wall & [and] allow to sit- Use scouring pad or cloth scrub wall- Use grout brush to get between tiles (if applicable)- Rinse completely."
- Observations on 8/27/12 at 3:00 PM and on 8/29/12 at 8:30 AM, revealed a dirt and wax buildup along the baseboards in rooms 400, 402, 403, 404, 406, 407, 408, 409, and 410.
- During an interview in the administrator's office on 8/29/12 at 1:40 PM, the floor technician stated, "...all baseboards on the 400 hall have been cleaned..."

**F 460**

483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY

**ID PREFIX TAG**

**PROVIDER'S PLAN OF CORRECTION**

- **F 253**: On 9/14/12 Director of Maintenance along with the Director of Housekeeping Services and the facility floor Tech were in-serviced on maintaining sanitary, orderly and comfortable interior, to include removal of dirt and wax buildup along the baseboards by the facility administrator. Rooms 400, 402, 403, 404, 406, 407, 408, 409, and 410 will be stripped and waxed by 9/30/12.

On 9/14/12 Director of Maintenance or designee conducted an audit of all resident rooms and common area and developed a stripping and waxing schedule based off priority need to ensure removal of dirt and wax buildup along baseboards.

All findings will then be reported to the facility's Quality Assurance (QA) committee for review and further recommendations. The QA committee consists of the Administrator, Director of Nursing, Medical Director, Assistant Director of Nursing, Dietary Manager, Social Services Director and Activities Director.

**F 460**: No adverse effects were noted as a result of this deficient practice. All residents have a potential to be affected by this deficient practice.
F 460 Continued From page 4

In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.

This REQUIREMENT is not met as evidenced by:

Based on policy review, observation and interview, it was determined the facility failed to ensure that bedrooms assured full visual privacy for 31 of 32 (Rooms 100, 101, 104, 105, 106, 107, 108, 109, 110, 200, 202, 203, 205, 206, 300, 301, 302, 303, 304, 305, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, and 410) resident rooms.

The findings included:

1. Review of the facility's "Quality of Life-Dignity" policy documented, "Policy Statement Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality... 10. staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures..."

2. Observations on 8/28/12 at 9:00 AM revealed room 100 had a privacy curtain around B and (A) C bed but no curtain around the A bed. The privacy curtains in resident rooms 101, 104, 105, 106, 107, 108, 109, and 110 only came down the center of the room between the beds and only reached the light fixture in the center of the room which did not provide full visual privacy for the resident.

On 9/4/12 administrator spoke with Textile Company regarding the need to have facility assessed for additional tracking and privacy curtains. On 9/11/12 Textile company was in the facility and measured all rooms for tracking and privacy curtains. On 9/13/12 facility entered into a contract agreement with Textile Company ordering tracking and privacy curtains for the facility to assure full visual privacy for each resident. Due to manufacturing time of making the tracking and privacy curtains on 9/14/12 all rooms were equipped with signs to notify staff and visitor that when the door is shut care is being provided and please wait before entering resident room (there is a 4-6 week delay in the facility receiving the tracking and privacy curtains.) On 9/19/12 and 9/26/12 staff will be in-serviced on assuring full visual privacy for each resident while providing care.

Maintaining of full visual privacy will be monitored by the DON or designee by conducting random observations of staff providing full visual privacy in rooms providing care weekly for four weeks, months for two months and randomly thereafter.

All findings will then be reported to the facility's Quality Assurance (QA) committee for review and further recommendations. The QA committee consists of the Administrator, Director of Nursing, Medical Director, Assistant Director of Nursing, Dietary Manager, Social Services Director and Activities Director.
During interview in room 106 on 8/30/12 at 10:12 AM, the administrator agreed the curtain did not provide visual privacy.

3. Observations on 8/28/12 at 3:00 PM, revealed rooms 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, and 410 had privacy curtains that were cane shaped around the A beds only. There was no privacy curtain in the rooms for the B beds.

4. Observations on 8/30/12 at 8:00 AM, revealed resident rooms 300, 301, 302, 303, 304, and 305 had privacy curtains in a cane shape around the A beds only. There were no privacy curtains for the B beds in any resident rooms on the 300 hall.

5. Observations on 8/30/12 at 2:00 PM, revealed the privacy curtains in resident rooms 202, 203, 205, and 206 only came down the center of the room between the beds and only reached the light fixture in the center of the room which did not provide full visual privacy. The privacy curtains in room 200 did not provide visual privacy for the 3 residents in this room.

During interview in room 202 on 8/30/12 at 10:17 AM, the administrator agreed the curtain did not provide visual privacy.

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.

No adverse effects were noted as a result of the deficient practice. All residents have the potential to be affected by this deficient practice.

On 8/30/12 a clarification order was written for resident #71 Enalapril Maleate 10mg to include the frequency of when the medication is to be administered. On 9/19/12 and 9/26/12 the
**DOUGLAS NURSING HOME**

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

2084 W MAIN ST
MILAN, TN 38358

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| F 514 |  | Director of Nursing will in-service licensed nurses on ensuring that all physician orders contain sufficient information to identify the resident, records of the resident’s assessments, the plan of care and the services provided. This is to include frequency for medications to be administered.

To ensure accuracy in physician orders facility Director of Nursing or Designate will randomly review 10 physician order weekly for four weeks, monthly for two months and randomly thereafter, ensuring that orders contain sufficient information to identify the resident, a records of the resident's assessments, the plan of care and the services provided.

All findings will then be reported to the facility’s Quality Assurance (QA) committee for review and further recommendations. The QA committee consists of the Administrator, Director of Nursing, Medical Director, Assistant Director of Nursing, Dietary Manager, Social Services Director and Activities Director. |

**F 514 Continued From page 6**

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

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to ensure physician's orders were accurate for 1 of 26 (Resident #71) sampled residents included in the stage 2 review.

The findings included:

Medical record review for Resident #71 documented an admission date of 6/2/12 with diagnoses of Diabetes Mellitus Type 2, Seizure Disorder, Depression, Hypertension, History of Cerebrovascular Accident with Dysphagia, Bipolar Disorder with Depression, Hyperlipidemia, and Dementia with Behavior Disturbances. Review of an admission order signed by the physician on 6/2/12 documented "ENALAPRIL MALEATE 10 mg [milligram]." There was no frequency for the medication to be administered documented on the order. Review of a transfer "Patient Medication Profile" documented "ENALAPRIL MALEATE 10 mg Two Times Daily." The frequency was not included on the admission orders.

During an interview at nurses' station 1 on 8/30/12 at 8:22 AM, Licensed Practical Nurse #1...
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<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSU IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<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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<td>F 514</td>
<td>Continued From page 7 stated, &quot;There should be a clarification order. The profile came from the hospital but the times are not on the admission orders signed by the Physician.&quot;</td>
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FORM CMS-2587(02-99) Previous Versions Obsolete
Event ID: X39F11
Facility ID: TN2702
If continuation sheet Page 8 of 8