F 177 483.10(o) RIGHT TO REFUSE CERTAIN TRANSFERS

An individual has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate a resident of a SNF, from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF, or a resident of a NF, from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF.

A resident's exercise of the right to refuse transfer under paragraph (o)(1) of this section does not affect the individual's eligibility or entitlement to Medicare or Medicaid benefits.

This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review and interview, it was determined the facility failed to ensure a resident had the right to refuse a transfer to another room for 1 of 20 (Resident #13) sampled residents. The facility's 132 beds are all dually certified.

The findings included:

Review of the facility's "Transfer of Resident Within the Facility" policy documented "Purpose... To provide resident with room of choice whenever possible... To provide calm atmosphere..."

Review of the facility's "Resident Rights" policy documented "...A change in room or roommate assignment as specified in §483.15(e)(2)... [The interpretive Guidelines for §483.15(e)(2)

1) What corrective action will be
Accomplished for those residents
found to have been affected
By the deficient practice?
The facility will ensure that a resident has
the right to refuse transfer. A social worker
spoke with resident #13 on 12/20/11, and
resident agreed for new room placement
upon room availability.

2) How will you identify other residents
Having the potential to be affected by
the same deficient practice?
A social worker completed an audit of all
Residents from 12/20/11 to 12/22/11 to
Confirm residents are satisfied with room
placement. Residents audited are satisfied
with current room placement.

3) What measures will be put into place or
What systemic changes will you make
to ensure that the deficient practice will
not recur?
A social worker completed education with
Facility associates including: activities, business
Office, admissions, dietary, environmental
Services, maintenance, marketing, medical
Records, nursing, rehab and social services on
12/20/11 on resident rights, including the right to
refuse transfer. A monthly audit of resident
transfers will be completed by a social worker
for three months to confirm resident approval
of transfer. The results of these audits will be
presented to the P.I. committee.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

EXECUTIVE DIRECTOR

12/22/11
F 177: Continued From page 1

documented ... The facility should be sensitive to the trauma a move or change of roommate causes some residents, and should attempt to be as accommodating as possible. This includes learning the resident's preferences and taking them into account when discussing changes of rooms or roommates and the timing of such changes...

Medical record review for Resident #13 documented an admission date of 4/29/10 with a readmission date of 6/28/10 with diagnoses of Atrial Fibrillation, Coronary Artery Disease, Hypertension, Psychosis and Depression. Review of a physician's order dated 10/6/11 documented, "Resident transferred to Room 109B from 307B." Review of the "Care Plan Conference Record" dated 11/2/11 documented, "...Room change to East 109B—he is not exactly pleased [symbol for with] the room..."

During an interview in Resident #13's room on 12/6/11 at 11:00 AM, Resident #13 stated, "...I was moved to this room [room 109B]... I didn't want to move... we [Resident #13 and spouse] were supposed to be next door [room 107], but when they brought us over we were moved into this room [room 109]..." Resident #13 was asked if he had a choice about the transfer, or the room he was moved to. Resident #13 stated, "No."

During an interview in the Social Services office on 12/7/11 at 9:17 AM, the Social Service Assistant Director (SSD) was asked why Resident #13 was transferred to room 109B. The SSD stated that the facility was in the process of making the rooms on the 300 hall skilled beds.
F 177, Continued From page 2

During an interview in the activity room on 12/7/11 at 10:15 AM, the Administrator was asked why Resident #13 was transferred to room 109B. The Administrator stated, that the facility "...was converting the 300 hall to Medicare rooms..."

F 274, 483.20(b)(2)(ii) COMPREHENSIVE ASSESS SSS=D | AFTER SIGNIFICANT CHANGE

A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to conduct a significant change of status for 1 of 20 (Resident #6) sampled residents.

The findings included:

Medical record review for Resident #6 documented an admission date of 6/9/11 with diagnoses of Hypertension, Anxiety, Pneumonia, Osteoporosis, Depression, Chronic Obstructive

1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?

The facility will ensure that a significant change of status is completed when needed. An MDS Nurse (LPN) confirmed the care plan of resident #6 was accurate according to the resident's status as of 12/21/11.

2) How will you identify other residents having the potential to be affected by the same deficient practice?

Two MDS nurses (RN & LPN) will complete an audit of resident assessments from 12/23/11 to 12/30/11 to ensure a significant change has been addressed.

3) What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur?

Two MDS nurses will complete a significant change audit monthly for three months. The results of these audits will be presented to the P.I committee.
Pulmonary Disease and Parkinson's Disease. Review of the initial Minimum Data Set (MDS) completed on 6/6/11 with a subsequent quarterly comprehensive MDS on 9/7/11 documented an improvement in 3 areas on the MDS. The areas of improvement were activities of daily living, bladder control and pain were not addressed until the quarterly MDS. There was no significant change MDS completed when improvement was shown in these three areas.

During an interview in the Activity Director's office on 12/7/11 at 1:15 PM, the MDS Coordinator stated, "Would not do the significant change unless it was consistently changed."

A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, it was determined the facility failed to have the Minimum Data Set (MDS) readily accessible for review for 2 of 20 (Residents #6 and 14) sampled residents.

The findings included:

1. Medical record review for Resident #6 documented an admission date of 6/9/11 with diagnoses of Hypertension, Anxiety, Pneumonia, Osteoporosis, Depression, Chronic Obstructive Pulmonary Disease and Parkinson's Disease. The MDS was requested on 12/5/11 after lunch,
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER
Life Care Center of Centerville

STREET ADDRESS, CITY, STATE, ZIP CODE
112 Old Dickson Rd
Centerville, TN 37033

_two MDS nurses (RN & LPN) will complete
A monthly audit of residents assessments to
Ensure accessibility. The results of these audits
will be presented to the P.I. committee.

_F 286 _Continued from page 4
_The MDS was not presented to the surveyor until
12/6/11 at 4:45 PM.

_2. Medical record review for Resident #14
_documented an admission date of 8/23/11 with a
readmission date of 10/22/11 with diagnoses of
Dementia with Psychosis, Diabetes Mellitus,
Hypertension, Anxiety Disorder and Depression.
The MDS was requested on 12/5/11, the MDS
was not presented to the surveyor until 12/7/11 at
9:00 AM.

_F 328 _483.25(k) TREATMENT/CARE FOR 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 policy review, medical record review,
observation and interview, it was determined the
facility failed to ensure that oxygen was
administered at the physician prescribed rate
and/or there was a physician's order for oxygen
for 3 of 4 (Residents #6, 7, and 16) sampled
residents receiving oxygen.

The findings included:
NAME OF PROVIDER OR SUPPLIER

LIFE CARE CENTER OF CENTerville

STREET ADDRESS, CITY, STATE, ZIP CODE
112 OLD DICKSON RD
CENTERVILLE, TN 37033

(X1) PROVIDER/SUPPLIER/CWA
IDENTIFICATION NUMBER: 445252

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
12/07/2011

THE SOURCE OF THE DEFICIENCY STATEMENT

F 286 Continued From page 4
the MDS was not presented to the surveyor until 12/6/11 at 4:45 PM.

2. Medical record review for Resident #14 documented an admission date of 8/23/11 with a
readmission date of 10/22/11 with diagnoses of Dementia with Psychosis, Diabetes Mellitus,
Hypertension, Anxiety Disorder and Depression. The MDS was requested on 12/6/11, the MDS
was not presented to the surveyor until 12/7/11 at 9:00 AM.

F 328 483.25(k) TREATMENT/CARE FOR SPECIAL
NEEDS

The facility must ensure that residents receive proper treatment and care for the following
special services:

- Injections;
- Parenteral and enteral fluids;
- Colostomy, ureterostomy, or ileostomy care;
- Tracheostomy care;
- Tracheal suctioning;
- Respiratory care;
- Foot care; and
- Prostheses.

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review, observation and interview, it was determined the
facility failed to ensure that oxygen was administered at the physician prescribed rate for 3 of 4
(Residents #6, 7, and 16) sampled residents receiving oxygen.

The findings included:

The P.I. Committee consisting of The Executive Director, Medical Director,
Business Office Manager, Director of Medical Records, Director of Environmental Service,
Director of Maintenance, Director of Social Services, Director of Admissions,
Director of Rehab Services, Director of Activities, Director of Food and Nutrition Services, and
Director of Marketing will review the findings and make recommendations and develop
plans of action if any areas are noted to be non-compliant.

F 286

1) What corrective action will be Accomplished for those residents found to have been affected
   By the deficient practice?

   The facility will ensure that oxygen is Administered at the prescribed physician’s Rate. A LPN confirmed during survey and
   on 12/22/11 that oxygen was administered at the physician prescribed rate for resident #6, 7, and 16.

2) How will you identify other residents Having the potential to be affected by the same deficient practice?

   LPN staff conducted an audit of all Residents from 12/21/11 to 12/30/11 to Confirm residents’ oxygen followed the
   Prescribed physician rate.

3) What measures will be put into place or What systematic changes will you make
to ensure that the deficient practice will not recur?
| F 328  | Continued From page 5 |

1. Review on the facility's "Re-Admissions (Continued Use of a Medical Record)" policy documented, "When a resident is discharged, with return anticipated, the information in the active medical record at the nurses' station is not removed, but remains in the medical record holder/binder for up to 14 days. The record and holder will continue to be used when the resident is re-admitted to the nursing facility. Upon the resident's return to the nursing facility: obtain new orders from the resident's physician. Do not accept "resume previous orders." Begin new medication and treatment administration records with the new orders-do not continue the previous records."


Observations in Resident #6's room on 12/5/11 at 4:00 PM and on 12/6/11 at 8:05 AM, revealed Resident #6 was receiving oxygen at a rate between 4.5 and 5 liters per nasal cannula.

A nurses note dated 12/6/11 at 16:05 (4:05 PM), documented, "This writer was called to Rm [room] found O2 between 4 and 5L. Turned O2 back to 4L..."
The facility failed to ensure Resident #6 received oxygen at the physician's prescribed rate.

2. Medical record review for Resident #7 documented an admission date of 11/21/11 with diagnoses of Shortness of Breath, Coronary Disease, Atrial Fibrillation, Severe End Stage Chronic Obstructive Pulmonary Disease and Heart Failure. The facility was unable to provide a current physician's order for oxygen therapy.

Observations in Resident #7's room on 12/5/11 at 9:20 AM and 1:55 PM, on 12/6/11 at 6:00 AM and on 12/7/11 at 8:00 AM, revealed Resident #7 was receiving oxygen at 2 liters per nasal cannula.

During an interview in the Activity Director's office on 12/7/11 at 2:10 PM, the Acting Director of Nursing stated, "He [Resident #7] doesn't have a current order for oxygen."

The facility failed to ensure there was a current physician's order for the oxygen being used.

3. Medical record review for Resident #16 documented an admission date of 1/18/10 with diagnosis of Parkinson's, Hypothyroidism, Bronchitis, Congestive Heart Disease and Hypertension. A physician's order dated 9/27/11 and recertified on 11/1/11 documented, "O2 at 3L [liters] / [per] MN [minute] BNC as needed." The care plan updated on 9/27/11 documented, "O2 @ 3LPM BNC PRN." Nurses notes dated 9/30/11 at 0225 (2:25 AM), 10/2/11 at 0200 (2:00 AM), 11/14/11 at 12:45 PM, 11/15/11 at 1500 (3:00 PM) and 11/18/11 at 0015 (12:15 AM) documented Resident #16 was receiving oxygen.
F 328 | Continued From page 7

at 2 liters per nasal cannula.

Observations in Resident #16's room on 12/5/11 at 10:00 AM, revealed Resident #16 lying in bed receiving oxygen at 2 liters a minute per nasal cannula.

The facility failed to administer Resident #16's oxygen at the physician's prescribed rate.

F 441 | 493.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

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.

1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?

The facility will prevent the possible spread of infection by cleaning and Disinfecting high touch surfaces. A Housekeeper cleaned the siderails on 12/7/11.

2) How will you identify other residents having the potential to be affected by the same deficient practice?

Housekeepers cleaned facility siderails on Resident beds on 12/8/11.

3) What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur?

Director of Environmental Services completed education with housekeeping staff on 12/13/11 on cleaning and sanitizing resident siderails. A weekly audit of resident siderails will be completed by the Director of Environmental Services.
F 441 Continued From page 8
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 policy review, observation and interview, it was determined the facility failed to prevent the possible spread of infection by failure to clean and disinfect a high touch surface (side rail) which was visibly soiled for 1 of 20 (Resident #15) sampled residents.

The findings included:
Review of the facility's "Daily Room Cleaning" policy documented, "...12. Using a damp rag [germicidal disinfectant and water] damp dust the room starting with the resident's area..."

Observations in room 112 on 12/5/11 at 10:05 AM and on 12/7/11 at 11:20 AM, revealed a brownish/red substance (appearance of blood) on the left upper siderrail of Resident #15's bed.

During an interview in room 112 on 12/7/11 at 11:25 AM, the Director of Environmental Services stated, "...I will take care of it..." The Director of Environmental Services was asked who was responsible for cleaning the bedrails. The Director of Environmental Services stated, "They [staff]

F 441 Services for sixteen weeks to confirm cleanliness of siderrails on resident beds. The results of these audits will be presented to the P.I committee. 12/30/11

4) How will the corrective action be accomplished for those residents found to have been affected by deficient practices?

The Director of Environmental services will present the findings of the Siderrail Audit to the Performance Improvement Committee Meeting monthly for four consecutive months. The P.I. Committee consisting of The Executive Director, Medical Director, Business Office Manager, Director of Medical Records, Director of Environmental Service, Director of Maintenance, Director of Social Services, Director of Admissions, Director of Rehab Services, Director of Activities, Director of Food and Nutrition Services, and Director of Marketing will review the findings and make recommendations and develop plans of action if any areas are noted to be non-compliant. 12/30/11
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(K1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:** 445252

**(K2) MULTIPLE CONSTRUCTION**

A. BUILDING

B. WING

**(X3) DATE SURVEY COMPLETED:** 12/07/2011

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**NAME OF PROVIDER OR SUPPLIER:** LIFE CARE CENTER OF CENTERVILLE

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 112 OLD DICKSON RD

CENTERVILLE, TN 37033

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**(X4) ID PREFIX TAG**

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 441</td>
<td>Continued From page 9 usually leave it for housekeeping.</td>
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<tr>
<td>F 465</td>
<td>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</td>
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<tr>
<td></td>
<td>The facility must provide a safe, functional, sanitary, and comfortable environment for</td>
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<td>residents, staff and the public.</td>
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<tr>
<td></td>
<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on observation and interview, it was determined the facility failed to provide a clean</td>
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<td>and sanitary environment as evidenced by rust on the framework of the over the commode chairs in</td>
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<td>5 of 57 resident rooms (room 100, 101, 105, 315 and 317) or dirty handrails on 2 of 3 days during</td>
</tr>
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<td>the survey.</td>
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<td></td>
<td>The findings included:</td>
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<tr>
<td></td>
<td>1. Observations of the facility during the initial tour on 12/5/11 beginning at 9:20 AM revealed</td>
</tr>
<tr>
<td></td>
<td>the following:</td>
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<tr>
<td></td>
<td>a. Room 100 - Rust on the framework of the over the commode chair.</td>
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<tr>
<td></td>
<td>b. Room 101 - Rust on the framework of the over the commode chair.</td>
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<tr>
<td></td>
<td>c. Room 105 - Rust on the framework of the over the commode chair.</td>
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<tr>
<td></td>
<td>d. Room 315/317 (shared bathroom) - Rust on the framework of the over the commode chair.</td>
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<td>During an interview in the 100 hall on 12/7/11 at 11:15 AM, the Director of Environmental</td>
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<td></td>
<td>Services confirmed that it was rust on the framework of the over commode chairs in rooms 100,</td>
</tr>
<tr>
<td></td>
<td>101, 105 and 317.</td>
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<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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</thead>
<tbody>
<tr>
<td>F 441</td>
<td>1) What corrective action will be Accomplished for those residents found to have been affected By the deficient practice?</td>
</tr>
<tr>
<td>F 465</td>
<td>The facility will ensure to provide a clean And safe environment. All hallway handrails Were cleaned by housekeeping staff on 12/6/11. New resident over the commode chairs in rooms 100, 101, 105, 315 and 317 have been ordered and will be replaced by 12/30/11.</td>
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<td>12/30/11</td>
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<tr>
<td>P465</td>
<td>2) How will you identify other residents Having the potential to be affected by the same deficient practice?</td>
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<tr>
<td></td>
<td>An audit was completed by the Director Of Environmental Services of over the bed Commodes on 12/21/11 to determine if any Other commodes needed replacement.</td>
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<td>12/30/11</td>
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<tr>
<td></td>
<td>3) What measures will be put into place or What systematic changes will you make to ensure that the deficient practice will not recur?</td>
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<tr>
<td></td>
<td>Environmental Services Director completed education with housekeeping associates on cleaning handrails on 12/13/11. A weekly audit will be conducted for sixteen weeks by the Environmental Services Director to ensure Cleanliness of handrails. A weekly audit of over The commode chairs will be conducted for Sixteen weeks by the Environmental Services Director. The results of these audits will be presented to the P.I committee.</td>
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<td>12/30/11</td>
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F 465 Continued From page 10

315/317.

2. Observations of the facility during the initial tour on 12/5/11 from 9:20 AM to 10:30 AM and on 12/6/11 from 8:40 AM to 9:30 AM, revealed the following:

a. Gray, brown and white substances and spider webs (some with dead bugs in them) on the 100, 200 and 300 hall handrails.

b. A dirty alcohol swab, a dirty glove, and a dark red substance on the 300 hall handrails.

c. Gum on the inside of a handrail between room 326 and the Beauty Shop.

During an interview on the 100 hall on 12/6/11 at 2:15 PM, the Director of Environmental Services and the Administrator confirmed the handrails were dirty.

F 465

4) How will the corrective action be accomplished for those residents found to have been affected by Deficient practice?

The Environmental Services Director will present the findings of the Handrail and over the course of the audit to the Performance Improvement Committee meeting monthly for three consecutive months. The P.I. Committee consisting of the Executive Director, Medical Director, Business Office Manager, Director of Medical Records, Director of Environmental Service, Director of Maintenance, Director of Social Services, Director of Admissions, Director of Rehab Services, Director of Activities, Director of Food and Nutrition Services, and Director of Marketing will review the findings and make recommendations and develop plans of action if any areas are noted to be non-compliant.

12/30/11