BRAEBBILL NURSING HOME INC.

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 155
SS=D

483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES

The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

This STANDARD is not met as evidenced by:

Based on medical record review and interview, the facility failed to assist three residents (#1, #3, #5) in securing an advance directive for end of life decisions of five residents reviewed.

The findings included:

- Resident #1 was admitted to the facility on March 27, 2013, with diagnoses including Diabetes, End Stage Renal Disease, Heart Disease, and Chronic Obstructive Pulmonary Disease.

- Medical record review revealed a Physician Orders for Scope of Treatment (POST) placed in

Corrective Action:

For resident #1, no opportunity to correct.

For resident #3, required signatures were obtained on 8/12/2013.

For resident #5, required signatures were obtained on 8/12/2013.

Identification of other residents having the potential to be affected:

No other residents were identified as having been affected.

Any deficiency statement ending 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 patient. (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.
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<th>ID PREFIX TAG</th>
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<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 155</td>
<td>Continued From page 1 the front of the resident's medical record. The POST document was executed on March 22, 2013, by a hospital Physician, five days prior to admission to the facility. The Physician's signature was not accompanied by the patient's and/or a surrogate's signature as required. Interview with the Director of Nursing on August 1, 2013, at 2:30 p.m., in the education room, confirmed the facility had failed to assist the resident during their thirty-eight day length of stay to secure a valid advanced directive. Resident #3 was admitted to the facility on July 8, 2013, with diagnoses including Cerebral Vascular Accident, Hypertension, and Asthma. Medical record review revealed a POST document placed in the front of the resident's medical record. Review of the POST revealed the document reflected the resident desired no attempt to be resuscitated (DNR) if found with no pulse and/or not breathing. The POST documented this as the patient's preference as discussed with the patient. The document was not signed by the patient/resident. The document was signed only by the resident's niece. The document did not contain the mandatory Physician and patient signatures for the DNR to be in effect. Interview with resident #3 on August 1, 2013, at 9:50 a.m., in their room, revealed an alert and oriented resident able to share pertinent details of their medical history, family dynamics, and goal to return home. Interview with the director of Nursing on August 5, 2013, at 3:30 p.m., in the education room, Measures to be put in place and systemic changes: Admissions Coordinator will review POST form with the resident, if appropriate. If indicated, the form will be presented to resident's responsible party and/or POA at time of admission to obtain signatures. Once admitted, depending on the time of admission, the unit secretary and/or unit charge nurse will present POST form to physician for review and signature. Monitoring of corrective actions: The Director of Nursing and/or Assistant Director will review all new POST forms within 72 hours of admission to verify all forms have been correctly filled out and signed. DON and/or ADON will report daily during the morning admission meeting compliance. POST form compliance will also be reviewed as an agenda item as a part of the monthly QA/QI process beginning 9/19/2013. This process will occur as an ongoing process during the...</td>
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### F 155

Continued from page 2

confirmed the facility had not assisted the resident in securing a valid advanced directive.

Resident #5 was readmitted to the facility on April 4, 2013, with diagnoses including Chronic Kidney Disease III, history of Cerebral Vascular Accident, Chronic Obstructive Pulmonary Disease, and history of Falls.

Interview with resident #5 on August 5, 2013, at 8:20 a.m., in their room, revealed an alert resident able to share details about breakfast, but not willing to talk about the past, specifically about previous roommates at the facility.

Medical record review revealed a POST document placed in the front of the resident’s medical record. Review of the POST revealed the document reflected the resident desired no attempt to be resuscitated (DNR) if found with no pulse and/or not breathing. The POST documented this as the patient’s preference and as discussed with the patient. The document was signed by the patient/resident and a facility employee. The POST document did not reflect the physician had discussed this with the resident and did not contain the mandatory physician signature for the DNR to be in effect.

Review of the resident's Care Plan revealed a Registered Nurse documented the resident's "Advanced Directives" had been reviewed on July 1, 2013.

Interview with the Director of Nursing on August 5, 2013, at 3:30 p.m., in the education room, confirmed the facility had not assisted the resident in securing a valid advanced directive.

- **F 155**
  - morning admission meeting
  - and monthly QA/QI meeting
  - according to established
  - meeting schedules and times.
F 155 Continued From page 3
C/O #31775

F 157
483.10(b)(11) NOTIFY OF CHANGES
(INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:

Brakebill Nursing and Rehabilitation agrees that a facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status in either life threatening conditions or clinical complications; a need to alter treatment significantly or to commence a new form of treatment; or a decision to transfer or discharge the resident from the facility.

Corrective Action:

Resident # 1
No opportunity to correct.
F 157 Continued From page 4

Based on medical record review and interview the facility failed to notify the physician and obtain emergency medical services for greater than sixty minutes for one unresponsive resident (#1) with a critically low blood glucose value of five residents reviewed.

The findings included:

Resident #1 was admitted to the facility on March 27, 2013, with diagnoses including Diabetes, End Stage Renal Disease, Heart Disease, and Chronic Obstructive Pulmonary Disease.

Review of Nurse’s Note dated May 4, 2013, at 8:10 a.m., revealed “This nurse went in room to give 8 AM po (by mouth) meds. Found resident unresponsive to tactile and verbal stimuli. This nurse did CS (onsite test for blood sugar level) 28 (critical level).”

Review of Nurse’s Note dated May 4, 2013, at 9:00 a.m., revealed “CS 88...still unresponsive to tactile/verbal stimuli or pain stimuli...Stat Care paged...new order...send to ER (Emergency Room).”

Review of the ambulance records revealed the resident was transported out of the facility at 9:35 a.m., on May 4, 2013.

Review of the ER Physician’s Initial exam revealed "...critical...airway fully obstructed..." Review of ER Physician’s Provider record revealed the resident was intubated in the ER and placed on a ventilator to assist with breathing.

Interview with Licensed Practical Nurse (LPN #1) in the education room on August 5, 2013, at 8:30
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<th>(X5) COMPLETION DATE</th>
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<td>Continued From page 5 a.m., revealed LPN #1 had the Certified Nursing Assistant (CNA) bring the LPN's Nurse Supervisor to the room when the resident's unresponsiveness and blood sugar value of 28 was assessed at 8:10 a.m., on May 4, 2013. Interview continued and the LPN stated, &quot;Didn't realize so many minutes had gone by...guess I was focused on getting blood sugar up.&quot;</td>
<td>F 157</td>
<td>reviewed by the Director of Nursing Services and/or Assistant Director of Nursing Services. An incident report will be generated in the event of a &quot;significant&quot; change or event and will be reviewed by the Director of Nursing Services and/or Assistant Director of Nursing Services. Monitoring of corrections will be a continued, ongoing program utilizing incident report reviews and will also be reviewed as an agenda item as a part of the facilities monthly QA/QI process according to the predetermined meeting schedule. This action will commence on 9/19/2013.</td>
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<td>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</td>
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The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported.

| F 225 | Brakebill Nursing and Rehabilitation Center does not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law or have had a finding entered into the State nurse aide abuse registry concerning abuse, neglect, mistreatment of residents or misappropriation of resident property. |
| SS=D  |                                                                 |
Continued From page 6
immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, review of facility documents and interview, the facility failed to report an allegation of abuse of one resident (#2) to the appropriate State agency of five residents reviewed.

The findings included:

Resident #2 was admitted to the facility on April 13, 2010, with diagnoses including Dementia, Cerebral Vascular Disease, and Diabetes.

Medical record review of the quarterly Minimum Data Set (MDS) dated March 5, 2013, revealed the resident was sometimes able to make self understood and usually understood others. Continued review of the MDS revealed the
Continued From page 7

resident had impaired cognition with modified independence in decision-making ability and a short-term memory problem.

Review of the Care Plan updated on March 5, 2013, revealed interventions for the resident's communication and cognition problems included the following: use short phrases that require yes and no answers; speak directly to resident in simple phrases; and verbal reminders and cues that assist resident in orientation.

Review of a facility document completed by Licensed Practical Nurse (LPN #2) on March 24, 2013, at 3:00 p.m., revealed "Resident reports to wife that (resident) was hit by male while in bed. (Resident) first stated...was hit on legs and moments later stated...was hit in face. (Resident) has no bruises, no marks, no skin tear, no swelling of face or legs."

Medical record review of an entry in the Nurses Notes revealed "3/26/13 late entry...to lobby - present was a Knoxville City Police Officer, resident's (spouse), daughter, and daughter-in-law. Police Officer stated 'I am responding to a report of assault...I need to see (resident #1) because the allegation has been made...''"

Interview with the Administrator in the education room on August 5, 2013, at 11:15 a.m., revealed the March 25, 2013, Nurses Note entry had been made by the former Director of Nursing at the Administrator's request. Interview confirmed the resident had lodged an allegation of abuse on March 24, 2013, and the State Agency had not been notified of the allegation as required.

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<td>F 225</td>
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immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including the State survey and certification agency. All alleged violations will be properly investigated according to State standards and reported to the State survey and certification agency utilizing the IRS reporting system. Resident's, family members, responsible parties and POA's of the resident who alleges an incident will not have the ability or option of retracting their allegation once an allegation is made.

Monitoring of corrective actions:

All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property will be reviewed during the daily morning staff meeting. Investigation results will be documented in the incident report and residents medical record. When entered
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<tr>
<th>ID</th>
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<th>Tag</th>
<th>Provider's Plan of Correction</th>
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<td>F 225</td>
<td>Continued From page 8 C/O #31660</td>
<td>F 225</td>
<td>into the State IRS system, a copy of the report will be filed with the incident report. All allegations will be reviewed as a part of the facility's monthly QA/QI process according to the predetermined meeting schedule. This action will commence on 9/19/2013.</td>
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<td>F 309</td>
<td>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</td>
<td>F 309</td>
<td>Brakebill Nursing and Rehabilitation Center believes that 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.</td>
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<td>Corrective action that will be accomplished for those residents found to have been affected:</td>
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**Findings included:**

- Resident #1 was admitted to the facility on March 27, 2013, with diagnoses including Diabetes, End Stage Renal Disease, Heart Disease, and Chronic Obstructive Pulmonary Disease.
- Medical record review revealed the resident had respiratory and renal complications following a colon resection in March 2013. Review of the Speech Therapy Notes revealed the resident had progressed from "nothing by mouth" to a mechanical soft renal diet.
- Record review of Social Services Notes revealed the resident had been going to in-center hemodialysis treatments three days a week with
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| F 309 | Continued From page 9  
the last treatment on May 2, 2013.  
Review of the facility's Patient Sign Out-In Sheet revealed the resident signed self out of the facility at 10:50 a.m., on May 3, 2013, and returned at 4:20 p.m. the same day.  
Review of the Nurse's Note dated May 4, 2013, 8:10 a.m., revealed "This nurse went in room to give 8 AM po (by mouth) meds. Found resident unresponsive to tactual and verbal stimuli. This nurse did CS (onsite test for blood sugar level) 28 (critical level)..."  
Review of a Nurse's Note dated May 4, 2013, 9:00 a.m., revealed "CS 88...still unresponsive to tactual/verbal stimuli or pain stimuli...Stat Care paged...new order...send to ER (Emergency room)."  
Medical record review of the Emergency Medical Technician's Treatment Summary and Narrative revealed "09:30...On scene, pt. (patient) lying in bed, unconscious, unresponsive with snoring respirations and saliva around mouth. Pillow behind head removed and airway aligned, snoring decreased...Staff states that approximately 0730 patient's BG (blood glucose) was 23, they gave Glucagon and it (blood glucose) increased to 87, but still unresponsive...Airway suctioned with thick saliva, mucous removed...Attempted to place OPA (oral airway) several times, but pt's jaw would not open...NPA (nasal airway) placed in left nostril with breathing improving...pt required suctioning 2 more times during transport."  
Review of the ER Physician's initial exam on May 4, 2013, at 9:50 a.m., revealed "critical...airway fully obstructed..." Review of ER Physician's  
| F 309 | Identification of other residents having the potential to be affected:  
No other residents were identified as having been affected.  
Measures to be put in place and systemic changes:  
Education and in-service training by the Director and/or Assistant Director of Nursing will be used for all nursing staff to communicate the need of recognizing life threatening conditions and the need to obtain emergency transport for residents when indicated. New nursing staff will be in-serviced as a part of their orientation.  
In-services will be completed by 9/19/2013.  
Monitoring of corrective actions:  
Monitoring of corrections will be by the Director and/or Assistant Director of Nursing Services whom will review documented actions taken by nursing staff to address critical...
F 309 Continued From page 10

Provider record revealed the resident was intubated in the ER and placed on a ventilator to assist with breathing.

Medical record review of the Discharge Summary (Death Summary) revealed "Date of Death: May 12, 2013...Reason for Hospitalization: Severe hypoglycemia and acute encephalopathy...This is a 70-year-old...found down...the morning of admission with a glucose of 23...brought to the Emergency Department...A thorough workup was done to identify any other causes of acute encephalopathy. The diagnosis was reached as irreversible brain damage due to prolonged hypoglycemia and Neurology was consulted to evaluate the patient as well and they came to the same conclusion."

Interview with licensed practical nurse (LPN #3) in the education room on August 2, 2013, at 8:35 a.m., revealed LPN #3 initially stated had only worked on the resident's unit from 3:00 p.m. to 7:00 p.m., on May 3, 2013. Continued interview revealed (after the LPN was shown documentation LPN #3 had recorded at 8:00 p.m.) LPN #3 stated "I guess I worked the whole sixteen hours here...I wasn't familiar with (resident) and had never taken care of (resident). Continued interview revealed and included a review of the record of blood glucose values recorded by LPN #3, including a value of 139 on the morning of May 4, 2013. Interview revealed LPN #3 stated the blood glucose was obtained at 6:00 a.m. and the resident aroused briefly and "put...hand out."

Interview with Licensed Practical Nurse (LPN #1) in the education room on August 5, 2013, at 8:30 a.m., revealed LPN #1 had the Certified Nursing
Assistant bring the LPN's Nurse Supervisor to the
room when the resident's unresponsiveness and
blood sugar (glucose) value of 28 was assessed
at 8:10 a.m. on May 4, 2013. Continued interview
revealed LPN #1 stated "Didn't realize how many
minutes had gone by...guess I was focused on
getting blood sugar up." Further interview
revealed LPN #1 stated "When the nurse called
from the emergency room and asked what (the
resident's) blood sugar had been at 6:00 a.m.
there wasn't a blood sugar recorded for 6:00 a.m.

Interview with the Director of Nursing (DON) in
the education room on August 1, 2013, at 3:15
p.m., confirmed the DON had been unable to
locate any policy and/or procedure related to the
treatment of low blood glucose values.
Continued interview with the DON confirmed the
Standing Orders for Administration of the Sliding
Scale Insulin included an order to notify the
physician for any blood glucose value of fifty or
below.

Interview with the Director of Nursing in the
education room on August 5, 2013, at 9:15 a.m.,
confirmed the delay in obtaining emergency
medical services when the resident was found
unresponsive with a critically low blood sugar.

C/O #31775