**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**N1102** 1200-8-6-.11(2) Records and Reports

(2) The nursing home shall report all incidents of abuse, neglect, and misappropriation to the Department of Health in accordance with T.C.A. § 68-11-211.

This Rule 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 as required 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 a quarterly assessment dated March 5, 2013, revealed the resident was sometimes able to make self understood and usually understood others. Review of the assessment revealed the resident had impaired cognition with modified independence in decision-making ability and a short-term memory problem.

Review of the Care Plan updated 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.

**N1102**
Brakebill Nursing and Rehabilitation Center ensures that the nursing home shall report all incidents of abuse, neglect, and misappropriation to the Department of Health in accordance with T.C.A. § 68-119211.

Corrective action that will be accomplished for those residents found to have been affected:

Resident #2: No opportunity to retroactively correct or input data into the IRS system.

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:

The facility will continue to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of
### Division of Health Care Facilities

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CIA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>TN4702</td>
<td>A. BUILDING:</td>
</tr>
<tr>
<td></td>
<td>B. WING:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(X3) DATE SURVEY COMPLETED:</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>08/06/2013</td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER:** BRAEBILL NURSING HOME INC.

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

5837 LYONS VIEW PIKE

KNOXVILLE, TN 37919

<table>
<thead>
<tr>
<th>(X4) ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X5) ID PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X6) COMPLETE DATE</th>
</tr>
</thead>
</table>
| N1102           |     | Continued From page 1

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 (residenet) was hit by male while in bed. (Resident) first stated...was hit on legs and moments later stated...was hit in face...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 "3/25/13 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, Nursing 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 facility had failed to report the allegation to the appropriate State Agency as required.

C/O #31660

<table>
<thead>
<tr>
<th>N1349</th>
<th>Policies and procedures for health care decisi</th>
</tr>
</thead>
<tbody>
<tr>
<td>1200-8-6-.13 (30)(e) Policies and procedures for health care decisi</td>
<td></td>
</tr>
<tr>
<td>(30) Universal Do Not Resuscitate Order (DNR).</td>
<td></td>
</tr>
<tr>
<td>(e) When a person with a Universal Do Not Resuscitate Order is transferred from one health care facility to another health care facility, the health care facility initiating the transfer shall</td>
<td></td>
</tr>
</tbody>
</table>

unknown source and misappropriation of resident property are reported 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. All alleged violations will be properly investigated according to State standards and reported to the State survey and certification agency utilizing the IRS reporting sstem. 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
N1349 Continued From page 2
communicate the existence of the Universal Do Not Resuscitate Order to the receiving facility prior to the transfer. The transferring facility shall assure that a copy of the Universal Do Not Resuscitate Order accompanies the individual in transport to the receiving health care facility. Upon admission, the receiving facility shall make the Universal Do Not Resuscitate Order a part of the individual's record. The POST form promulgated by the Board for Licensing Health Care Facilities shall serve as the Universal Do Not Resuscitate Order form when transferring an individual from one health care facility to another health care facility.

This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure Physician's Orders for Scope and Treatment (POST) on admission where followed up on and completed for end of life decisions of three residents (#1, #3, #5) 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 POST form placed in the front of the resident's medical record. The POST form had been 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 and

medical record. When entered 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 facilities monthly QA/QI process according to the predetermined meeting schedule. This action will commence on 9/19/2013.

N1349

It is the practice of Brakebill Nursing and Rehabilitation Center to recognize that a 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.

Corrective Action:

For resident #1, no opportunity to correct. Resident discharged on 5/4/2013.

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

For resident #5, required signatures were obtained on 8/12/2013.
N1349 Continued From page 3

the facility had failed to provide any follow up to ensure the resident's current wishes were obtained and a Physician's signature was obtained.

Interview with the Director of Nursing on August 1, 2013, at 2:30 p.m., in the education room, confirmed the facility had not assisted the resident during their thirty-eight day length of stay to secure a Physician's signature.

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 form placed in the front of the resident's medical record. Review of the POST form 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 had not been signed by the patient/resident. The document had been 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, confirmed the facility had failed to assist the resident in securing a valid advanced directive.

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:

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
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 form placed in the front of the resident’s medical record. Review of the POST form revealed the resident desired no attempt to be resuscitated (DNR) if found with no pulse and/or not breathing. The POST form revealed this as the patient’s preference as discussed with the patient. The POST form was signed by the patient/resident and a facility employee. The POST form did not reflect the Physician had discussed this with the resident and did not contain the mandatory Physician's 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 failed to assist the resident in securing a valid advanced directive.

C/O #31775