Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because of the provisions of 42 CFR 405.51907 and state regulations require it.

The Facility will provide privacy to residents in all rooms during times of patient care via privacy curtain or closed doors.

A. There were no residents harmed by these practices.

B. All rooms were checked and no other issues were found to cause harm to other residents and provide privacy.

C. The Housekeeping department is responsible for monitoring the cubicle curtains for cleanliness and proper functioning.

1. The Housekeeping department re-installed the curtain in room 110 which was down for cleaning on 4/30/13.

2. The bed in room 118 was repositioned within the room to remove the direct visibility from the hallway on 4/30/13. This is a private room.

3. In room 206, the Maintenance department detangled the curtain hooks to function correctly in the tracks to provide for the curtain to extend around bed.

4. In room 210, the maintenance Department detangled the hooks to function correctly in the track to provide for the curtain to fully extend around the bed.

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 patients. (See instructions.) Except for nursing homes, the findings stated above are discernable 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 discernable 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.
The findings included:

1. Observations in room #110 on 4/28/13 at 3:07 PM and on 4/30/13 at 2:40 PM, revealed no privacy curtain for bed 1 in a semi-private room.

   During an interview in room 110 on 4/30/13 at 2:40 PM, Nurse #2 confirmed bed 1 did not have a privacy curtain.

2. Observations in room 118 on 4/28/13 at 11:30 AM, revealed a private room with no privacy curtain. The resident's bed was in full view from the door way.

   During an interview in room 118 on 4/30/13 at 2:42 PM, Nurse #2 confirmed there was no privacy curtain in room 118.

3. Observations in room 206 on 4/28/13 at 5:23 PM and on 4/30/13 at 2:45 PM, revealed the privacy curtain did not extend all the way around bed 2 to provide full visual privacy.

   During an interview in room 206 on 4/30/13 at 2:45 PM, Nurse #2 was asked about the privacy curtain in room 206. Nurse #2 stated, "...it [privacy curtain] goes half track..." Nurse #2 confirmed the privacy curtain did not extend all the way around bed 2.

4. Observations in room 210 on 4/28/13 at 3:07 PM, the privacy curtain on the track around bed 1 would not pull to provide full visual privacy.

   During an interview in room 210 on 4/30/13 at 2:48 PM, Nurse #2 was asked about the difficulty
**NAME OF PROVIDER OR SUPPLIER**

COUNTRYSIDE HEALTHCARE AND REHABILITATION

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

3051 BUFFALO ROAD

LAWRENCEBURG, TN 38464

<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tbody>
<tr>
<td>F 164</td>
<td>Continued From page 2 of pulling the privacy curtain around bed 1. Nurse #2 stated, &quot;The tracks are bent.&quot;</td>
<td>F 164</td>
<td>The Facility will adhere to the rule of reporting all allegations of abuse to the State Department of Health.</td>
</tr>
<tr>
<td>5. During an interview on the 100 hallway on 4/30/13 at 2:55 PM, Assistant Director of Nursing (ADON) was asked if each resident should have a privacy curtain. The ADON stated, &quot;Yes.&quot;</td>
<td></td>
<td>A. This resident was not harmed by the situation that it was reported as the arm that she was referring to was due to a rotator cuff issue.</td>
<td></td>
</tr>
<tr>
<td>F 225</td>
<td>483.13(c)(1)(i)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</td>
<td>F 225</td>
<td>B. All residents have the potential to be harmed if there is ongoing abuse in the facility not being investigated and reported. No others have been found to have been harmed.</td>
</tr>
<tr>
<td>SS=D</td>
<td>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 they have 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.</td>
<td></td>
<td>C. Any allegation of abuse will have the investigation started immediately with notification to the Abuse Coordinator which will give direction to the staff on duty to proper procedure and per company policy. The resident will be assessed for harm and the employee accused will be suspended until the investigation is complete. The Administrator, Abuse Coordinator and/or designee will come to the facility to assist in the investigation at the earliest possible time and ensure that it is being completed correctly and that statements are obtained and that policy is being followed. The Abuse Policy and the Resident Rights were both serviced by DON and Administrator to the entire staff on Friday April 19, 2013.</td>
</tr>
</tbody>
</table>

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 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...
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<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 225</td>
<td>Continued From page 3 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 policy review, medical record review, and interview, it was determined the facility failed to ensure that an allegation of abuse was thoroughly investigated and reported to the state survey and certification agency for 1 of 3 (Resident #15) investigations of abuse. The findings included: Review of the facility's &quot;Abuse Prevention Program&quot; policy documented, &quot;...Our abuse prevention program provides policies and procedures that govern, as a minimum... Timely and thorough investigations of all reports and allegations of abuse... The reporting and filing of accurate documents relative to incidents of abuse...&quot; Review of the facility's &quot;Reporting Resident Abuse&quot; policy documented, &quot;...The nurse supervisor must complete a Resident Abuse Form...&quot; Review of the facility's &quot;Abuse Investigations&quot; policy documented, &quot;...All reports of resident abuse... shall be promptly and thoroughly investigated by facility management... Should an</td>
<td>F 225</td>
<td>2. All allegations of abuse will be reported within 5 days from the date of notification through the Incident Reporting Service. 3. In-services are being conducted by the DON and Risk Manager from 5/3/13 and will continue until all staff has been re-in-serviced. 4. Investigative forms will be made available at Nurses Stations to adhere to policy.</td>
<td>5/20/13</td>
</tr>
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</table>

2. All allegations of abuse will be reported within 5 days from the date of notification through the Incident Reporting Service.

3. In-services are being conducted by the DON and Risk Manager from 5/3/13 and will continue until all staff has been re-in-serviced.

4. Investigative forms will be made available at Nurses Stations to adhere to policy.

D. All investigations will be monitored by the Administrator and the Abuse Coordinator and will be brought to the QAPI committee (consisting of medical Director, Director of Nursing, Administrator, Nursing supervisors, Social services and other Department Supervisors) each month for 3 months and then quarterly thereafter to assure continued compliance.
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<td>F 225</td>
<td>Continued From page 4</td>
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incident or suspected incident of resident abuse, mistreatment... be reported, to the administrator, or his/her designee, will appoint a member of management to investigate the alleged incident...
The individual conducting the investigation will...
Review the completed "Resident Abuse Form"
...Interview the resident's... family members, and visitors... Interview other residents to whom the accused employee provides care... The results of the investigation will be recorded on the "Resident Abuse Investigation Report Form..."

Review of the facility's "Protection of Residents During Abuse Investigations" policy documented, "...Within five (5) working days of the alleged incident, the facility will give the... state survey and certification agencies... a written report of the findings of the investigation..."

Review of the facility's "Reporting Abuse to Facility Management" policy documented, "...Upon receiving reports of physical or sexual abuse, a licensed nurse or physician shall immediately examine the resident. Findings of the examination must be recorded in the resident's medical record... The person performing the examination must complete a "Resident Abuse Report Form"... Upon receiving information concerning a report of abuse, the director of nursing services will request that a representative of the social services department monitor the resident's reactions to and statements regarding the incident and his/her involvement in the investigation... Unless the resident requests otherwise, the social service representative will give the administrator and the director of nursing services a written report of his/her findings..."
**COUNTRYSIDE HEALTHCARE AND REHABILITATION**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<td>F 225</td>
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Review of the facility's "Staff Responsible for Coordinating / Implementing Abuse Prevention Program Policies and Procedures" documented, "...The administrator has the overall responsibility for the coordination and implementation of our facility's abuse prevention program policies and procedures..."

Medical record review for Resident #15 documented an admission date of 7/13/12 and a readmission date of 2/20/13 with diagnoses of Pneumonia, Muscle Weakness, Abnormal Gait, Dementia, Osteoarthritis, Dysphagia, Diabetes Type 2, Hypothyroidism, Hyperlipidemia, Leukocytosis, Depression, Obstructive Sleep Apnea, Tremor, Restless Leg Syndrome, Chronic Pain, Legal Blindness, Hypertension, Coronary Artery Disease, Congestive Heart Failure, Gastro Esophageal Reflux Disease, Gastric Diveritculum, Chronic Kidney Disease, Fibromyalgia, Anxiety, and Chronic Obstructive Pulmonary Disease. Review of the daily skilled nursing notes dated 4/20/13 and 4/21/13 revealed no documentation of Resident #15 resisting care.

Review of the documentation of the investigation of the alleged abuse incident for Resident #15 documented, "Summary of Investigation... The Administrator was notified on Sunday April 21 [2013] of an Incident involving resident [#15] and C.N.A. [Certified Nursing Assistant #3] stating that [Named Resident #15] had commented that C.N.A. named [CNA #3] had been in her room and had jerked her arm during the night. Upon arriving at the facility, statements were taken and discussion with resident and family determined that the placement of lap buddy was when the incident occurred. [Named Nurse #4]
### Continued From page 6

and C.N.A. [Named CNA #5] were the ones who placed the lap buddy and [Named CNA #3] was not in the room. There was never an allegation of abuse by resident or family, but investigation was conducted as such. There were no findings of Abuse in the investigation. Review of the written statement by Nurse #3, east wing charge nurse on duty at the time of the incident, documented, "[Named CNA #4] came to me and told me that [Named Resident #15] told her that the male CNA [#3] that was working the night shift 4/20/13 had pulled the Residents [#15] arm and Resident [#15] stated he pulled it back and it hurt, Family was here and came to the desk voicing their concern. Charge nurse [#3] called the House Supervisor and she came and spoke to the Family..." Review of the written statement by CNA #4 documented, "On 4-21-13 I was CNA on Group 2 and...was giving [Named Resident #15] a bath and she was telling me that [Named CNA #3] had jerked [jerked] her arm and it was hurting her and that he had twisted it...I told charge nurse [Named Nurse #3] what she had said and that I didn't think she was making it up..." Review of the written statement by Nurse #5, House Supervisor on duty at the time of the incident, documented, "4/21/13 Was called to East Wing by charge nurse. The son-in-law met me in the hallway to speak to me about his mother-in-law [Named Resident #15]...He said that [Named Resident #15] said her "arm was sore"..." Review of the documentation of the investigation of the alleged abuse incident for Resident #15 revealed there was no Resident Abuse Form or Resident Abuse Investigation Report Form completed as required per the facility's abuse prevention, reporting, and investigating policies, and there was no report of the alleged abuse being filed with the state survey.
Continued From page 7 and certification agency.

During the stage 1 resident interview in Resident #15's room on 4/29/13 at 8:52 AM, Resident #15 was asked have you ever been treated roughly by staff. Resident #15 stated, "Yes... They twisted my arm about 3 weeks ago... His name was [Named CNA #3]..." Resident #15's son-in-law was present during interview and confirmed the resident reported the incident to staff. Resident #15's son-in-law stated he reported the incident to the charge nurse on the hall at that time.

During an interview at the east nurses' station on 4/29/13 at 5:44 PM, Nurse #6, hall manager, was asked if she was aware of any reports of abuse involving Resident #15 on 4/20/13, Nurse #6 stated, "No one has reported anything to me." Nurse #6 was asked if Resident #15 ever resists care. Nurse #6 stated, "She does not like males caring for her... We had a male tech [Named CNA #3] up there..."

During an interview in the Administrator's office on 4/29/13 at 8:25 PM, the Social Services Director (SSD) was asked if she had any issues she had worked on with Resident #15 or her family. The SSD stated, "I haven't had any issues to deal with with that resident [#15]..."

During an interview in the day room on 4/29/13 at 6:40 PM, the Administrator stated, "...We looked into that on [Named Resident #15]... The CNA [Named CNA #3] that she said did that wasn't even in the room that night... People have been talking and getting things stirred up..."

During an interview at the central nurses' station...
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(x1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
<th>(x2) MULTIPLE CONSTRUCTION</th>
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<tbody>
<tr>
<td>445280</td>
<td>A. BUILDING:</td>
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<td>B. WING:</td>
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<td>04/30/2013</td>
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**NAME OF PROVIDER OR SUPPLIER**

COUNTRYSIDE HEALTHCARE AND REHABILITATION

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

3051 BUFFALO ROAD
LAWRENCEBURG, TN 38464

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**SUMMARY STATEMENT OF DEFICIENCIES**

| F 225 | Continued From page 8 on 4/30/13 at 8:39 AM, the SSD was asked for information regarding any abuse allegations by Resident #15. The SSD stated, "I don't know anything about them [allegations]..." The SSD was asked if abuse allegations should be reported to her. The SSD stated, "I would expect them to... if they were already tending to it, I wouldn't expect them to tell me though... I'm not here full time..."

During an interview in the day room on 4/30/13 at 9:49 AM, the Administrator was asked about the abuse allegation by Resident #15 on 4/20/13 and 4/21/13. The Administrator stated, "There was not an allegation of abuse..." The Administrator was asked to explain the written statement made by Nurse #4 who received the report of abuse. The Administrator stated, "That was not an allegation of abuse... I talked to the son-in-law... and other people on duty... I don't think that was an allegation... they said it was resisting care..." The Administrator was asked would you not consider the statement by the resident that the male CNA pulled the resident's arm and twisted it as an allegation of abuse. The Administrator stated, "No, it was during care... and he [accused CNA] was not even in the room..." The Administrator was asked what would you consider a full investigation of abuse. The Administrator stated, "...Talk to the person who was injured... son-in-law... all staff..." The Administrator was asked why the incident was not reported to the state agency as an abuse allegation. The Administrator stated, "If it was an allegation, I would have reported it... I didn't see that as an allegation of abuse. I saw that as a resistance to care..." |
Continued From page 9

During an interview in the Director of Nursing's (DON) office on 4/30/13 at 2:14 PM, the DON was asked for information regarding the report of abuse by Resident #15. The DON stated, "I know they talked to the charge nurse... I didn't interview the resident or the son-in-law..."

During an interview in the Assistant Director of Nursing's (ADON) office on 4/30/13 at 2:30 PM, the Administrator stated, "I didn't interview the son-in-law directly... he wasn't here the next day when I came in..."

During an interview at the east nurses' station on 4/30/13 at 2:58 PM, Nurse #3 was asked for information of the incident reported to her on 4/21/13 involving Resident #15. Nurse #3 stated, "She [Resident #15] had voiced to a CNA about it... I talked to the son-in-law..."

The facility Administrator failed to recognize an allegation of abuse, the facility failed to thoroughly investigate an alleged allegation of abuse by not completing a Resident Abuse Form or Resident Abuse Investigation Report Form as required by the facility's policies. The facility failed to report an allegation of abuse to the state survey and certification agency within 5 days of the reported allegation.

The facility will maintain accurate assessments for dental concerns.

A. No residents were harmed by this practice.

B. No other residents have been found to be harmed by this practice.
**F 278** Continued From page 10

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

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.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to accurately assess residents with dental concerns for 2 of 21 (Residents #89 and 99) sampled residents of the 30 residents included in the stage 2 review.

The findings included:

1. Medical record review for Resident #89 documented an admission date of 1/8/13 with diagnoses of Altered Mental Status, Convulsions, Personal History of Fall and Insomnia. Review of the admission Minimum Data Set (MDS) dated
F 278. Continued From page 11

1/13/13 documented, "...L0200. Dental... B. No natural teeth or tooth fragment(s) (edentulous)...
[no check]... Z. None of the above were present...
[checked]..." Review of the resident data set (RDS) dated 1/5/13 documented, "...[checked]
Admission... D. ORAL HEALTH STATUS (Check all that apply)... IF DENTURES... Full set upper and lower [checked]..." The MDS was not accurate for dental concerns for Resident #89.

2. Medical record review for Resident #99 documented an admission date of 11/25/11 and a readmission date of 4/5/12 with diagnoses of Schizophrenia, Dementia with Behavior Disturbance, Diabetes, Bipolar Disorder, Benign Prostatic Hypertrophy, Chronic Liver Disease, Psychosis, Hypertension, Hyperlipidemia, Delusional Disorder, and Insomnia. Review of the RDS dated 4/5/12 documented, "...Re:Admission [checked]... CONDITION OF TEETH... No Natural teeth or tooth fragments [checked]... IF DENTURES... Full Set upper and lower [checked]... DENTURES FIT PROPERLY... Yes [checked]... refuses denture adhesive...
[checked]... Review of the annual MDS with an assessment reference date of 11/21/12 documented "...Section L - Oral/Dental Status L0200. Dental... Z [checked]...
" (indicating none of the above). The option of "...B. No Natural teeth or tooth fragment(s) (edentulous)..." was not checked. The MDS was not accurate for dental concerns for Resident #99.

3. During an interview in the day room on 4/30/13 at 8:30 AM, The MDS Coordinator was questioned concerning the dental section on the MDS. The MDS Coordinator stated, "If they [the residents] have dentures, then we don't check..."
**COUNTRYSIDE HEALTHCARE AND REHABILITATION**

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<tbody>
<tr>
<td>F 278</td>
<td>Continued From page 12 that. I will go and check the manual...&quot;</td>
<td>F 278</td>
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<td></td>
<td>During an interview in the day room on 4/30/13 at 8:45 AM, the MDS Coordinator confirmed Resident #69 and Resident #99's MDS was inaccurate. The MDS Coordinator stated, &quot;I guess that was my fault...&quot;</td>
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<tr>
<td>F 371</td>
<td>483.35(i) FOOD PROCUREMENT, STORE/PREPARE SERVE - SANITARY</td>
<td>F 371</td>
<td>The Facility will adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness.</td>
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<td>The facility must -</td>
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<tr>
<td></td>
<td>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</td>
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<td>(2) Store, prepare, distribute and serve food under sanitary conditions</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on policy review, observation and interview, it was determined the facility failed to ensure food was served and stored under sanitary conditions as evidenced by food items left in the cooler past the expiration date; opened food items stored in the freezer left open to air; dietary staff not wearing hair covers in the kitchen and dirty fans in the dish wash room on 2 of 3 (4/28/13 and 4/29/13) days of the survey. Three (3) of 12 staff members (Certified Nursing Assistant (CNA) #1, #2 and Nurse #1) failed to use hand sanitizer or wash their hands while serving food to residents.</td>
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<td>The findings included:</td>
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(a) The sour cream was removed on 4/28/13.  
(b) The mustard was removed on 4/28/13.  
(c) The butter and rolls were removed and disposed of on 4/28/13.  
2. Hair coverings will be worn by all persons entering dietary and around food preparation and serving areas.  
(a) A permanent container for hair nets has been placed outside the entrance to the kitchen and the CDM and dietary staff will monitor daily for compliance and for refill of container.  
3. All employees are required to wash hands before serving residents, after collecting soiled plates, PRN.
## F 371

Continued From page 13

1. Review of the facility's "Refrigerators and Freezers" policy documented, "...All food shall be appropriately dated to ensure proper rotation by expiration dates..." Use by dates will be completed with expiration dates on all prepared on all prepared food in refrigerators... and "use by" dates indicated once food is opened. Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired or past perish dates..."

a. Observations in the walk in refrigerator on 4/28/13 at 11:30 AM revealed the following:
   a. A 5 pound tub of sour cream with an opened date of 2/20 with approximately 3/4 of the item gone with a best by date of 4/13, the date was smeared and unable to see the expiration date due to a smear over the date.
   b. A gallon container of mustard with an opened dated of 4/11 with a furry black substance with the appearance of mold scattered on the top and around the sides of the container.

During an interview in the walk in refrigerator on 4/26/13 at 11:50 AM, the Certified Dietary Manager (CDM) was asked how long items are good after opened. The CDM stated, "...3 days..."

During an interview in the walk in refrigerator on 4/28/13 at 11:50 AM, the CDM was asked what the substance might be. The CDM replied, "I'm like you, I honestly don't know..." and removed the containers of the sour cream and the mustard.

b. Observations in the walk in freezer on 4/28/13 at 11:40 AM, revealed 1 box of butter and egg
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<tr>
<td>F</td>
<td>371</td>
<td>Continued From page 14 dinner rolls opened with the plastic opened exposing the rolls to the air.</td>
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<td>371</td>
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During an interview in the kitchen on 4/28/13 at 11:50 AM, the CDM was asked if this was acceptable for the food item to be open to the air while stored. The CDM stated, "No."

2. Review of the facility's "Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices" policy documented, "...Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils..."

Observations in the kitchen on 4/28/13 revealed the following:

a. At 11:50 AM - the CDM was in the kitchen with no hair cover on her head.
b. At 12:00 PM - dietary staff member #1 walked into the kitchen without a hair cover.

During an interview in the kitchen on 4/29/13 at 2:15 PM, dietary staff members #2 and #3 confirmed everyone that enters the kitchen must wear hair coverings, and when the dietary staff come to work, someone in the kitchen must hand them a hair covering because the coverings are kept in the back room.

During an interview in the day room on 4/30/13 at 2:15 PM, the CDM was asked why the hair coverings were not kept close to the entry door of the kitchen. The CDM replied, "I thought the same thing..."

3. Review of the facility's "Food Preparation and Service" policy documented, "...Food service
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<tr>
<td>F 371</td>
<td>Continued From page 15 staff, including nursing services personnel, will wash their hands before serving food to residents. Employees also will wash their hands after collecting soiled plates and food waste prior to handling food trays...</td>
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Review of the facility's "Handwashing/Hand Hygiene" policy documented, "...The facility considers handwashing/hand hygiene as the primary means to prevent the spread of infections... All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents... If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% [percent] ethanol or isopropanol for all the following situations... Before direct contact with residents. After contact with a resident's intact skin; After contact with objects (...medical equipment) in the immediate vicinity of the resident..."

Observations in the 400 hall on 4/28/13 at 12:00 PM, Certified Nursing Assistant (CNA) #2 did not wash her hands prior to or after serving trays in rooms 400, 403, 407 bed - 2, 417 beds 1 and 2.

Observations in the central dining room on 4/28/13 revealed the following:

a. At 12:05 - CNA #1 went to the food cart, obtained a tray of food, served the tray to a resident, opened all food items removing cellophane and covers from the food. CNA #1 returned to the food cart to obtain another tray and did not sanitize her hands.

b. At 12:10 PM - CNA #1 touched all of the trays left on the cart, obtained a tray and served the tray to a resident. CNA #1 did not use gel or wash
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<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 371</td>
<td>Continued From page 16</td>
<td>F 371</td>
<td>4. All vents and fans in dietary will be maintained in a sanitary condition. Maintenance has added this to the monthly preventive maintenance program and will be additionally monitored by the Administrator, CDM and/or Designee on a weekly basis and added to the maintenance work order as a PRN situation. 5. Dietary staff was in-serviced on 5/7/13 for proper hand washing, proper stock handling, cleaning, wearing of head covers and reporting of need for cleaning of vents and fans to Maintenance. All staff will be in-serviced by RN/Risk Manager and/or LPN/Clinical Managers 5/10/13 on hand washing via return demonstration to correct these practices. Observation by Nursing Supervision, RD, CDM and/or designee will be performed on an on-going basis to assure that his practice has been corrected and will be followed with PRN training, written warnings and/or termination as needed. D. 1. The CDM and Nursing Supervision will monitor the results of the correction and report the findings to the QAPI committee (consisting of medical Director, Director of Nursing, Administrator, Nursing supervisors, Social services and other Department Supervisors) for the next three months and then every 6 months to assure continued compliance.</td>
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Observations in the 400 hall on 4/29/13 revealed the following:

a. At 5:40 PM - Nurse #1 delivered a tray to room 400, touching the resident and the bedside table and set up the tray without washing her hands. Nurse #1 then went to room 410, set up the tray touching the bedside table without washing her hands. Nurse #1 then went to room 407 B, set up the tray touching the bedside table, she did wash her hands after this resident.

b. At 5:57 PM - Nurse #1 knocked on the door, entered room 416, moved the resident's cane to the side of the bed and placed the over bed table in front of a wheelchair, went to the food cart and obtained a tray and placed the tray on the overbed table, assisted the resident to the wheelchair, and then set up the tray without washing her hands.

During an interview in the Director of Nursing's (DON) office on 4/30/13 at 7:55 AM, the DON stated, "All staff passing out trays should wash their hands prior to passing trays in the halls and dining areas... if the staff touch any objects prior to passing out trays or following I expect them to wash their hands..."
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<td>F 371</td>
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<td>Continued From page 17 from the food service line to assure that a sanitary environment is maintained...&quot;</td>
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Review of the facility's "Sanitation" policy documented, "...Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime..."

Review of the facility's "Monthly Preventative Maintenance" schedule provided by the Maintenance Director did not include cleaning and maintenance for the exhaust fan or the fan in the dishroom.

Observations in the dishroom on 4/29/13 at 9:55 AM, revealed an exhaust fan on the wall above the clean dish side of the dishroom with dust and grease on the fan and a fan mounted on the wall above the dirty side of the dishroom with dust and dirt on the fan grill.

During an interview in the kitchen on 4/29/13 at 10:00 AM, the CDM was asked who is responsible for cleaning the vents and fans in the kitchen. The CDM stated, "Maintenance." The CDM was then asked if she thought the vents and fans were dirty and needed to be cleaned. The CDM stated, "Yes."

During an interview in the locked unit hall beside the nurses' station on 4/30/13 at 9:20 AM, the Director of Maintenance was asked if the exhaust fan and the fan in the dishroom are cleaned when the air conditioner filters and vents are cleaned. The Director of Maintenance stated, "The exhaust fan and the fan in the dishroom are not on routine maintenance schedule. They will be added."
Continued From page 18

During an interview in the day room on 4/30/13 at 9:25 AM, the Maintenance Director was asked if the exhaust fan and the fan in the dishroom were cleaned on 4/2/13 with the air conditioner unit grill. The Director of Maintenance stated, “No, they were pretty dirty I'd say it's probably been at least 2 months.”

F 412 483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS

The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review, and interview, it was determined the facility failed to provide dental services for 2 of 4 (Residents #62 and #86) sampled residents reviewed of for dental concerns of the 30 residents included in the stage 2 review.

The findings included:

1. Review of the facility's "Dental Examination / Assessment" policy documented, "...Policy Interpretation and Implementation...1. Prior to, or within ninety (90) days after admission, the
F 412 Continued From page 19

1. Upon Admission, Social Services Director/Designee will put all residents on the dental services list within 72 hours of admission to be seen by dental services on their next visit or referred to their personal dentist prior to or within 90 days of their admission date unless otherwise indicated.

2. Social Services Director/or Designee will bring dental list to morning meeting daily for review by the IDT to ensure all new residents have been added to the list along with any residents with dental concerns.

3. Any dental concerns will also be noted by LPN Charge Nurse on 24 hour report and those needing emergency treatment will be secured an appointment date and treated by a dentist as soon as possible.

4. In-service to Charge Nurses will be done regarding dental assessment upon admission beginning 5/10/13 and continued until all charge nurses are signed off.

D. The above practice will be reported to the QAPI Committee (consisting of medical Director, Director of Nursing, Administrator, Nursing supervisors, Social services and other Department Supervisors) by the social worker.

And Nursing supervision on a monthly basis for 3 months and then quarterly thereafter to assure continued compliance.

During an interview in Resident #62's room on 4/28/13 at 3:25 PM, Resident #62 stated, "I don't have all my teeth..."
F 412  Continued From page 20

3. Medical record review for Resident #89 documented an admission date of 1/8/13 with diagnoses of Altered Mental Status, Convulsions, History of Fall and Insomnia. Review of the RDS dated 1/8/13 documented, "...[check mark] Admission... D. ORAL HEALTH STATUS (Check all that apply)... IF DENTURES... Full set upper and lower [check mark]..." Review of the physician's progress notes dated 1/17/13 documented, "...ROS [review of system]; neg [negative] x [except] teeth problems..." The facility was unable to provide a dental assessment for Resident #89.

During an interview in Resident #89's room on 4/28/11 at 3:51 PM, Resident #89 stated my dentures are loose.

During an interview in the day room on 4/30/13 at 7:50 AM, the Administrator stated, "...we're not finding it [dental evaluation]..."

During an interview in the day room on 4/30/13 at 9:30 AM, the Minimum Data Set Coordinator confirmed Resident #89 did not have a dental evaluation.

4. During an interview in the Director of Nursing's (DON) office on 4/30/13 at 8:10 AM, the DON stated, "...everybody doesn't get one [dental evaluation]... only those who have a problem of some sort..."

F 468

SS=E

483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS

The facility must equip corridors with firmly secured handrails on each side.

The facility will adhere to the life Safety codes by assuring that hand rails are firmly secured.

A. No residents were harmed by this practice.
NAME OF PROVIDER OR SUPPLIER: COUNTRYSIDE HEALTHCARE AND REHABILITATION

COUNTRY: TN

STREET ADDRESS, CITY, STATE, ZIP CODE: 3051 BUFFALO ROAD, LAWRENCEBURG, TN 38464

DATE SURVEY COMPLETED: 04/30/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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<tr>
<th>ID</th>
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<td>F468</td>
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<td>B. No other residents expressed harm from this practice.</td>
<td>5/10/13</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
<td>C. All handrails noted by surveyors were repaired on 5/6/13 on 100, 300, the secure unit and 500 hall. All other rails throughout the building were checked on 5/6/13 and determined to meet requirements per regulation. Handrails will be checked weekly times 3 months and then on the monthly Preventive Maintenance program to assure on going compliance by Maintenance personnel.</td>
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<td>Based on document review, observation and interview, it was determined the facility failed to ensure handrails were securely fastened to the walls on 3 of 5 (100, 300 and 500 halls) halls and the secured unit.</td>
<td>D. Results of the weekly checks will be brought to the QAPI committee (consisting of medical Director, Director of Nursing, Administrator, Nursing supervisors, Social services and other Department Supervisors) monthly by the Maintenance department for 3 months and then reported in the monthly safety committee meeting thereafter with reports made to the QAPI Committee annually.</td>
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<td>The findings included:</td>
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<td>1. Review of the facility's &quot;Monthly Preventative Maintenance&quot; documented, &quot;...Check for handrails secured tightly...&quot;</td>
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<td>2. Observations of an environmental tour of the facility on 4/30/13 beginning at 1:30 PM revealed the following:</td>
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<tr>
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<td>a. The 100 hall had a loose handrail by room 120.</td>
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<td>b. The 300 hall had a loose handrail by room 302.</td>
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<td>c. The entrance to the secured unit had a loose handrail</td>
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<td>d. The 500 hall had a loose handrail by room 533 and between room 534 and room 535.</td>
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<td>3. During an interview in the day room on 4/30/13 at 9:25 AM, the Maintenance Supervisor confirmed that checking the handrails to ensure they were secured tightly to the wall was on the preventative maintenance checklist.</td>
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