**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID</th>
<th>PROVIDER/SUPPLIER IDENTIFICATION NUMBER</th>
<th>DATE SURVEY COMPLETED</th>
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<tbody>
<tr>
<td>F221</td>
<td>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RERAINTS</td>
<td>08/22/2011</td>
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**SUMMARY STATEMENT OF DEFICIENCIES**

- The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

**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 complete a restraint assessment, obtain an order or consent for ankle belts while up in the wheelchair for 1 of 1 (Resident #5) sampled residents with physical restraints.

**The findings included:**

- Review of the facility's "PHYSICAL RESTRAINT REDUCTION PROGRAM" policy documented, "1. Evaluate the resident's condition prior to use of restraints for potential concerns by completing the pre-restraining assessment... 2. A physician's order will be obtained... 3. Explain the procedure in advance to the resident and family, and obtain the informed consent."

- Medical record review for Resident #5 documented an admission date of 5/13/08 with diagnoses of Brain Injury, Paraplegia, Joint Contractures and Dysphagia. Review of the physician's recertification orders dated 6/11 did not include an order for the ankle belts while up in the chair. Review of the pre-restraining assessment dated 6/2/11 did not include assessment for ankle belts. The facility was unable to provide documentation of a consent for physical restraints.

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**RECEIVED**

**DATE**

**FORM APPROVED**

**OMB NO. 0938-0931**

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**LABORATORY DIRECTOR OF PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE**

**DATE**

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the facility may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)
F 221 Continued from page 1

the use of ankle belts.

Observations in Resident #5's room on 6/21/11 at 10:00 AM and 12:15 PM and on 6/22/11 at 1:00 PM, revealed Resident #5 sitting in the wheelchair with bilateral ankle belts in place.

During an interview at the north nurses' station on 6/22/11 at 1:00 PM, Nurse #3 stated she did not know the ankle belts were being used and confirmed there was no assessment for the ankle belts.

During an interview at the north nurses' station on 6/22/11 at 1:06 PM, Nurse #7 confirmed there should be an order, an assessment and a consent for the ankle belts in use.

During an interview on the north hall on 6/22/11 at 1:08 PM, Nurse #1 was asked how long the ankle belts had been used. Nurse #1 stated, "...quite a while... at least 6 months..."

F 278

483.20(g) - (j) ASSESSMENT
ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

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.

F 278

The assessment will accurately reflect the resident's status.

1. Corrective action for residents affected: Resident #5 MDS was corrected and transmitted to reflect the use of limb restraint on 6/22/11 by MDSC.

2. Identification of others who could be affected by the deficient practice: DON, MDSC, ADONs, Medical Records Director will complete review of most recent MDS on all other residents for coding errors completed on 7/8/11

3. Measures put in place to ensure deficient practice does not recur: The Interdisciplinary Team will review MDs assessments weekly before transmission. Any coding errors that are identified will be immediately corrected.
Name of Provider or Supplier: HEALTHCARE OF COLUMBIA

State Address, City, State, Zip Code: 1410 TROTWOOD AVENUE COLUMBIA, TN-38401

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<thead>
<tr>
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<tr>
<td>F 278</td>
<td>Continued From page 2</td>
<td>F 278</td>
<td>4. Systems to monitor the effectiveness:</td>
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<td>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, observation and interview, it was determined the facility failed to ensure the Minimum Data Set (MDS) was accurately coded for limb restraints for 1 of 1 (Resident #5) sampled residents with physical restraints. The findings included: Medical record review for Resident #5 documented an admission date of 5/13/98 with diagnoses of Brain Injury, Paraplegia, Joint Contracture and Dysphagia. Review of the quarterly MDS dated 6/2/10 for section P for limb restraint was not assessed to reflect the use of bilateral ankle belt restraints. Observations in Resident #5's room on 6/2/11 at 10:00 AM and 12:15 PM and on 6/22/11 at 1:00 PM, revealed Resident #5 sitting in the</td>
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| F 278         | Continued From page 3 wheelchair with bilateral ankle belts in place:  
During an interview at the north nurses’ station on 6/22/11 at 1:00 PM, Nurse #3 stated she did not know the ankle belts were being used and confirmed the ankle belts should have been coded on the MDS.  
During an interview on the north hall on 6/22/11 at 1:00 PM, Nurse #1 was asked how long the ankle belts had been used. Nurse #1 stated, "...quite a while... at least 6 months..." | F 278         |                                                                                                  |
| F 280         | 483.20(a)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  
The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning, care and treatment or changes in care and treatment.  
A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  
This REQUIREMENT is not met as evidenced | F 280         | 1. Corrective action for resident's affected:  
1. MDSC and DON reviewed and updated Care Plan for Resident #5 to reflect no restraint on 6/24/11.  
2. MDSC and DON reviewed and updated Care Plan for Resident #5 to reflect no ROM on 6/24/11.  
3. MDSC and Respiratory Therapist reviewed and updated Care Plan for Resident #5 to reflect Oxygen therapy on 6/24/11.  
2. Identification of others who could be affected by the deficient practice:  
1. After review of all residents with positioning devices and/or specialty wheelchairs it was determined that the facility has no other residents with a restraint.  
2. DON completed a Care Plan audit of all residents with contractures for ROM indications on 7/5/11. No other corrections were necessary.  
3. MDSC completed a Care Plan audit of all residents receiving Oxygen therapy on 6/22/11. No other corrections were necessary. |
F 260 Continued From page 4

By:________________________

Based on policy review, medical record review, observation and interview, it was determined the facility failed to revise the comprehensive care plan to reflect the current status of residents for range of motion, restraints or the use of oxygen for 2 of 21 (Residents #5 and #8) sampled residents.

The findings included:

1. Review of the facility's "CARE PLANNING" policy documented, "...The plan of care shall be individualized, based on the diagnosis, resident assessment, and personal goals of the resident and his/her family. The planning for care, treatment and services will include the following: Care planning is based on data collected from the resident assessments with integration of those assessment findings in the care planning process... The needs of the resident, goals, time frames, required services and the service settings are critical considerations in determining the plan of care. Regular reviewing and revising the plan for care, treatment and services... the plan of care will consider strategies to limit the use of restraints and/or seclusion as appropriate to the condition of the resident..."

2. Medical record review for Resident #5 documented an admission date of 5/13/08 with diagnoses of Brain Injury, Paraplegia, Joint Contractures and Dysphagia. Review of the comprehensive care plan dated 6/3/11 documented, "...DO NOT PERFORM ROM [range of motion] D/T [due to] HIGH RISK FOR FRACTURES... Staff will provide PROM [passive range of motion] as resident tolerates during
F 280 Continued From page 5

bathing...and documented no interventions of ankle belts while in the wheelchair. The care plan was not revised to reflect the current ROM interventions or the use of ankle belts while up in the wheelchair.

Observations in Resident #5's room on 6/21/11 at 10:00 AM and 12:15 PM and on 6/22/11 at 1:00 PM, revealed Resident #5 sitting in the wheelchair with bilateral ankle belts in place.

During an interview on the north hall on 6/22/11 at 9:50 AM, Nurse #6 confirmed Resident #5 receives ROM during bathing and dressing.

During an interview at the north nurses station on 6/22/11 at 1:00 PM, Nurse #3 stated she did not know the ankle belts were being used and confirmed the ankle belts should have been put on the care plan.

During an interview on the north hall on 6/22/11 at 1:08 PM, Nurse #1 asked how long the ankle belts had been used. Nurse #1 stated, "...quite a while... at least 6 months...".

During an interview in the Minimum Data Set Office on 6/22/11 at 2:15 PM, Nurse #3 confirmed the care plan had not been updated to reflect the current status for ROM and use of bilateral ankle belt restraints.

3. Medical record review for Resident #8 documented an admission date of 3/10/10 with diagnoses of Osteoporosis, Alzheimers, Dementia, Osteoarthritis, Anorexia, Depression, Attention Gastrostomy and Epilepsy. Review of the physician’s orders dated 5/3/11 with a start
### Statement of Deficiencies and Plan of Correction

**F 280** Continued From page 8

- keto is [greater than] or = [equal] to 90% [percent]. Review of the Minimum Data Set (MDS) with an assessment reference date of 4/15/11 documented Resident #8 received O2 therapy within the last 14 days. Review of the care plan dated 4/18/11 revealed no documentation for the use of O2.

Observations in Resident #8’s room on 6/20/11 at 11:25 AM, 3:00 PM and 5:00 PM, and on 6/21/11 at 8:00 AM and 2:45 PM, revealed Resident #8 lying in bed receiving O2 at 2 1/2 liters per min to an invasive cannula.

During an interview in the MDS office on 6/22/11 at 7:45 AM, Nurse #3 confirmed there was no care plan for the use of O2 and stated, "...thought she [Resident #8] had been weaned off O2, want to check on this and then will put on the care plan... needs a care plan for difficulty breathing..."

**F 309 SS=D**

Provide Care/Services for Highest Well Being

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.

This REQUIREMENT is not met as evidenced by:
- Based on medical record review, observation

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**F 309**

- Each resident will receive and the facility will 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

1. Corrective action for residents affected: Nurse #4 removed water pitcher with straw and cup with straw from room and replaced with controlled flow cup on 6/22/11.

2. Identification of others who could be affected by the deficient practice:
   - All residents using adaptive equipment have the potential to be affected.

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**Completion Date 7/8/11**
<table>
<thead>
<tr>
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<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<tr>
<td>F 309</td>
<td>Continued From page 7 and Interview; it was determined the facility failed to follow physician's orders by allowing 1 of 24 (Resident #11) sampled residents to use a straw for liquids. The findings included: Medical record review for Resident #11 documented an admission date of 2/17/11 with diagnoses of Cerebral Palsy, Mental Retardation, Dysphagia and Psychosis. Review of the physician's order dated 3/22/11 documented, &quot;...Mechanical soft diet w [with] thin controlled flow cup for all liquids - no straws...&quot; Review of the care plan dated 2/28/11 documented, &quot;...(05) Provide adaptive equipment as needed. Resident is sometimes able to hold sippy cup in her right hand... no straw...&quot; Observations in Resident #11's room on 6/20/11 at 6:30 PM, revealed a flow cup at the resident's bedside with coffee and a straw in the cup. Observations in Resident #11's room on 6/21/11 at 7:55 AM, revealed a regular cup with coffee and a straw in the cup. During an interview at the north nurses' station on 6/22/11 at 10:05 AM, Nurse #4 stated, &quot;...she [Resident #11] doesn't have an order for no straw...&quot; During an interview in Resident #11's room on 6/22/11 at 10:10 AM, Nurse #4 stated, &quot;...she [Resident #11] has a water pitcher with a straw...&quot;</td>
<td>F 309</td>
<td>3. Measures put in place to ensure deficient practice does not recur: 1. Audit of all residents with ordered adaptive equipment for meals in accordance with CDM and CNA. Plan of care for accuracy and compliance completed 6/20/11 by DON and CDM 2. In-service of CNA's, Licensed Nurse, &amp; Therapists regarding following MD orders for adaptive equipment completed on 7/8/11 with new staff to be in-service during orientation period.</td>
<td>7/8/11</td>
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<tr>
<td>F 333</td>
<td>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</td>
<td>F 333</td>
<td>The facility will ensure that residents are free of any significant medication errors</td>
<td>7/8/11</td>
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Continued From page 8
The facility must ensure that residents are free of any significant medication errors.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation and interview, it was determined the facility failed to ensure that residents were free of significant medication error when 1 of 7 (Nurse #2) nurses observed during medication administration pass made a significant medication error by failing to ensure ordered blood pressure was obtained prior to administration of an antihypertensive medication.

The findings included:
Medical record review for Resident #4 documented an admission date of 8/5/02 with diagnoses of Diabetes Mellitus, Hypertension, Spondylosis and Vascular Dementia. Review of a physician's order dated 6/7/11 documented, "...B/P [blood pressure] checked three times daily before Clonidine dose..."

Observations in Resident #4's room on 6/20/11 at 4:55 PM, Nurse #2 administered Clonidine to Resident #4 without taking the blood pressure prior to administering Clonidine which resulted in a significant medication error.

During an interview at the north nurses' station on 6/21/11 at 12:15 PM, the Director of Nursing (DON) was asked if the nurses should obtain a resident's blood pressure prior to administration of an antihypertensive medication when ordered by the physician. The DON stated "...yes..."
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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

445465

**(K2) MULTIPLE CONSTRUCTION**

A. BUILDING
B. WING

**(K3) DATE SURVEY COMPLETED:**

06/22/2011

**NAME OF PROVIDER OR SUPPLIER:**

SIGNATURE HEALTHCARE OF COLUMBIA

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

1410 TROTWOOD AVENUE
COLUMBIA, TN 38401

**X4) ID PREFIX TAG**

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

**ID PREFIX TAG**

**BASELINE PLAN OF CORRECTION**

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)

**COMPLETION DATE**

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>F 362 483.35(u) SUFFICIENT DIETARY SUPPORT PERSONNEL</th>
<th>F 362 P362 The facility will employ sufficient support personnel competent to carry out the functions of the dietary service</th>
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<tbody>
<tr>
<td></td>
<td><strong>The facility must employ sufficient support personnel competent to carry out the functions of the dietary service.</strong></td>
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<td><strong>This REQUIREMENT is not met as evidenced by:</strong></td>
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<td><strong>Based on policy review, observation and interview, it was determined the facility failed to ensure that meal trays were delivered in a timely manner for 1 of 2 (supper on 6/20/11) dining observations on 1 of 3 (North) halls.</strong></td>
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<td><strong>The findings included:</strong></td>
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<td><strong>Review of the facility's &quot;Meal Service&quot; policy documented, &quot;...staff should be prepared / ready for meal service prior to established time of service to avoid delays in serving...&quot;</strong></td>
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<td><strong>Observations on the north hall on 6/20/11 revealed the north hall cart #1 was delivered to the floor at 5:35 PM. Certified Nursing Assistant (CNA #1) served the first tray from cart #1 at 5:35 PM.</strong></td>
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<td><strong>Observations on the north hall on 6/20/11 revealed the north hall cart #2 was delivered to the floor at 5:50 PM. CNA #1 served the first tray from cart #2 at 5:53 PM.</strong></td>
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<td><strong>Observations on the north hall on 6/20/11 revealed CNA #2 removed the last 3 trays from cart #1 and placed them on cart #2 at 5:15 PM.</strong></td>
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<td><strong>1. Corrective action for resident's affected:</strong></td>
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<td><strong>Staffing pattern adjusted to add one additional CNA to evening meal service as of 6/21/11</strong></td>
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<td><strong>2. Identification of others who could be affected by the deficient practice:</strong></td>
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<td><strong>All residents have the potential to be affected.</strong></td>
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<td><strong>3. Measures put in place to ensure deficient practice does not recur:</strong></td>
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<td><strong>1. Meal service audit completed on 3 halls during evening meal service 6/24/11 by ADON and DON revealed trays to be served in a timely manner.</strong></td>
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<td><strong>2. In-service of all Licensed Nursing Staff on duty during meal service times regarding provision of assistance with meal service completed on 7/8/11 with new staff in-serviced during orientation period</strong></td>
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<td><strong>4. Systems to monitor the effectiveness:</strong></td>
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<td><strong>1. Random audit by DON/ADON/Restorative Nurse Manager/Licensed Nurse on evening meal service per week on 3 halls weekly for 4 weeks and monthly thereafter</strong></td>
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<td><strong>2. All results will be presented to the QA Committee monthly for review and recommendations. Members of the QA Committee: Administrator, DON, Medical Director, Medical Records Director, two ADONs, Restorative Nurse Manager, Respiratory Therapist, Dietary Manager, Activity Director, Social Services Director, MDS Coordinator, Housekeeping Director, Rehab Services Manager, Maintenance Director</strong></td>
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Observations on the north hall on 6/20/11 revealed the last tray from cart #2 was served at 7:00 PM.

The total serving time for the supper meal on 6/20/11 was 1 hour and 25 minutes.

During an interview on the south hall on 6/22/11 at 7:55 AM, the Director of Nursing confirmed, "...one and a half hours is too long for meal serving..."

F 441 483.65 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
Continued From page 11

- direct contact will transmit the disease;
- (3) The facility must require staff to wash their 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 observation and interview, it was determined 2 of 7 (Nurses #2 and 5) nurses failed to clean equipment and provide infection control practices to prevent cross contamination after use of a glucometer.

The findings included:

1. Observations at the south hall medication cart outside room #76 on 6/20/11 at 5:02 PM, Nurse #2 placed the glucometer on top of the medication cart without the use of a barrier after obtaining a blood specimen. Nurse #2 placed the contaminated glucometer on the medication cart and did not clean the medication cart.

2. Observations in the south hall nurses' station on 6/20/11 at 4:20 PM, Nurse #5 placed the glucometer on top of the medication cart without the use of a barrier after obtaining a blood specimen. Nurse #5 placed the contaminated glucometer on the medication cart and did not clean the medication cart.
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<td>F 441</td>
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3. During an Interview in the Director of Nursing's (DON) office on 6/22/11 at 12:55 PM, the DON stated, "...Glucometers are cleaned before taking in the room by folding the cloth and using clean corner for each side of the glucometer then dry for one minute before using... Clean again before placing on cart..."