Amended 2557 for tags F480 and F520.

On July 11-15, 2011 an annual re-certification survey and Investigation of complaint #s TN27949, TN26609, TN26248 and TN25207 were completed.

The facility was cited with an Immediate Jeopardy at F280, F282, F332, F480 and F520, all with a scope and severity of a "J". The facility's failure to provide adequate supervision to prevent injuries from falls, develop and implement interventions to protect the resident after each of these falls placed Resident #3 in immediate jeopardy as evidenced by repeated falls with serious injuries that required medical interventions, and resulted in substandard quality of care.

An extended survey was completed on July 15, 2011.

The Administrator was informed of the Immediate Jeopardy on July 14, 2011 at 5:17 PM, in the Administrator's office.

An Allegation of Compliance (AOC) was received from the facility on 7/14/11 at approximately 8:00 PM with additional information received and accepted on 7/15/11 at 6:05 PM.

The AOC the facility presented to the survey team documented the following corrective measures put in place:
1. Failing Star Program (policy/procedure for prevention of falls) updated 7/14/11.
2. Quality Assurance (QA) Plan of Correction dated 7/14/11, documented nurse aide will...
<table>
<thead>
<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 000</td>
<td>Continued from page 1: Provide 1 on ( ) supervision of Resident #3 for 30 days to observe bed exit attempts, wheelchair exit attempts, bowel and bladder (B&amp;B) patterning. Beginning 7/14/11, staff will be inserviced upon next working shift on falling star program. Fall risk committee to meet weekly to address every fall and evaluate devices and effectiveness of interventions and documented in the QA fall team minutes.</td>
<td>F 000</td>
<td>Cross-referenced to the appropriate deficiency</td>
<td>07/16/2011</td>
</tr>
</tbody>
</table>

During an interview in Resident #3's room on 7/15/11 at 9:35 AM, CNA #5 stated her assignment for that shift was to provide 1 on ( ) 1 care for Resident #3, document Resident #3's toileting concerns each hour and document any attempts to exit the bed or the wheelchair (w/c). CNA #5 stated she was told someone will be assigned to the resident for 30 days.

During an interview at the #1 Nursing Station on 7/15/11 at 9:40 AM, Nurse #5 stated, "1:1 supervision will be continued 30 days and re-evaluated until we know she (Resident #3) is safe at the highest level of functioning."

An exit conference was conducted with the Administrator, Quality Assurance Nurse, Activity
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<tr>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>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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<tr>
<td>F 000</td>
<td>Continued From page 2</td>
<td>Director, Social Service Director, Care Plan Coordinator, Housekeeping Supervisor and the other staff members in the New Dining dining room on 7/15/11 at 7:45 PM. The facility staff were informed of the survey findings of the immediate jeopardy identified on 7/14/11 and the Immediate Jeopardy being removed as of 7/16/11 when the corrective action plan that was put in place at 5:05 PM.</td>
<td>F 000</td>
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<tr>
<td>F 164</td>
<td>483.10(e), 483.75(i)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</td>
<td>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this</td>
<td>F 164</td>
<td></td>
<td></td>
<td>7/19/11</td>
<td>F164</td>
<td>A. Signs were made to post on Activity Room doors when any resident group activity is in progress. Resident Council group was informed of this and staff was in-serviced on 07/15/11.</td>
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<tr>
<td>ID PREFIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
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<td>F 164</td>
<td>Continued From page 3 section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</td>
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<td>The resident’s right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</td>
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<td>The facility must keep confidential all information contained in the resident’s records, regardless of the form or storage methods, except when release is required by transfer to another health care institution; law; third party payment contract; or the resident.</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on observation, it was determined the facility failed to provide privacy for 8 of 9 (Residents #1, 10, 14 and 15 and Random Residents (RR) #4, 7, 8, 9 and 10) alert and oriented residents attending the group interview, when the meeting was interrupted by a staff member.</td>
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<td>The findings included: Observations during the group interview, in the activity room on the new wing, on 7/12/11 at 9:30 AM, with Residents #1, 10, 14 and 15 and RR #4, 7, 8, 9 and 10 present, a maintenance staff member entered the room at 9:35 AM and 9:55 AM without knocking or requesting permission to enter.</td>
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**F 167** 483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE

**F 164**

**B.** Activities will be announced overhead 15 minutes prior to scheduled activity to alert residents and staff that the activity is closed for resident's privacy. Resident Council meeting will be announced 15 minutes prior to meeting and staff will be informed that it is a closed session.

**C.** Activity Policy changed to reflect the new announcement schedule. Activity Director oversaw the staff on 07/19/11 and 07/22/11 about the closed meetings. Social Services will do quarterly resident interviews to ensure that there have been no interruptions. “Do Not Disturb” signs are posted on the Activity room doors by the Activity Director when resident group meetings are in progress.

**D.** Social Services will do quarterly interview with residents to ensure privacy is respected. Findings will be reported to the QA Committee. Social Services to monitor randomly, by direct observation.
A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.

The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.

This REQUIREMENT is not met as evidenced by:

Based on observation and interview, it was determined the facility failed to post a notice indicating the availability of the survey results and failed to ensure the survey results were readily accessible for all residents in the facility. The facility had a census of 98 residents.

The findings included:

Observations of the facility on 7/13/11 at 2:20 PM, revealed there was no notice posted indicating the location and availability of the survey results. The survey results notebook was located in a plastic wall container, in a corner by the business office window, approximately 5 feet from the floor with no notice to indicate the survey results were in the plastic wall container. The survey results were not readily accessible to wheelchair bound residents.

During the group interview, in the activity room on the new wing, on 7/12/11 at 9:30 AM, the nine residents identified as alert and oriented by the facility (Residents #1, 10, 14 and 15 and Random Residents #4, 7, 8, 9 and 10) stated they did not know where the survey results were posted and
<table>
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<tr>
<th>ID</th>
<th>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>F 167</td>
<td>Continued from page 5 had not seen them. During an interview in the Administrator's office, on 7/14/11 at 10:55 PM, the Administrator stated, he &quot;moved [survey results] by the business office because they kept stealing them off the bulletin board. Moved them [survey results] out of the parlor 3 or 4 years ago.&quot;</td>
<td>F 167</td>
<td>Administrator will check monthly to ensure that both Notice and Survey Results are posted. Social Services Director and Activities Director will monitor Resident's understanding through their quarterly assessments.</td>
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<tr>
<td>F 174</td>
<td><strong>RIGHT TO TELEPHONE ACCESS WITH PRIVACY</strong> The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.</td>
<td>F 174</td>
<td><strong>A.</strong> A cordless telephone has always been available at the Nurses Station for residents to make and receive personal phone calls. All resident rooms are equipped with a private telephone line/jack for direct dial. On 7/18/11 Social Services Director and Activities Director met with Resident's Council to review Resident's Rights which included the right to have privacy during telephone conversations.</td>
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<tr>
<td><strong>SS=E</strong></td>
<td><strong>483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY</strong></td>
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**SUMMARY STATEMENT OF DEFICIENCIES**
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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<tr>
<td>F 174</td>
<td>RR #10</td>
<td>Stated that residents could not have private conversations even if they have their own phone. Observations of the facility on 7/12/11 at 9:40 PM, revealed a pay telephone outside the &quot;Office&quot; door of the business office by the double doors leading to the front lobby. A &quot;Handicap Accessible&quot; sign was posted by the telephone. Observations outside of the business office on 7/13/11 at 2:20 PM, revealed the pay telephone did not have a dial tone for a customer to be able to dial 911 in an emergency when the receiver was picked up. During interview in the lobby area across from nurses' station 1 on 7/13/11 at 2:35 PM, RR #12 stated &quot;Does not have telephone...Makes calls from the desk (and pointed to the nurses station 1 desk)... Does not know if there is a cordless telephone...&quot; During an interview in the business office on 7/13/11 at 2:45 PM, the Administrator stated the pay phone &quot;used to work. Told the quarters out of it recently.&quot; The surveyor informed him that there was not a dial tone and he replied, &quot;You need a quarter.&quot; The Administrator then came out of the business office and went to the pay phone, picked up the receiver, placed a quarter in the slot and still did not receive a dial tone. During an interview in the Administrator's office on 7/14/11 at 10:55 PM, the Administrator stated that the residents can use the pay phone in the lobby to make telephone calls. The Administrator was asked what if the residents wanted to make A new phone was purchased by the facility to be available for all residents to use within the privacy of their own room. Notice was posted of phone availability. Staff was instructed on phone availability for residents by Social Services Director and designee on 7/22/11.</td>
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Continued From page 7

a private phone call. The Administrator stated that there was a cordless phone behind the reception desk, or the facility has a phone that can be taken to a resident’s room. None of the residents in the group interview indicated knowledge that they could use either of these phones.

When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident’s clinical record must be documented. The documentation must be made by the resident’s physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(v) of this section.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to ensure documentation was made by the residents physician when discharge was necessary for 1 of 3 (Resident #19) sampled residents that had been discharged from the facility.

The findings included:

Medical record review for Resident #19 documented an admission date of 12/9/10 with diagnoses of Chronic Obstructive Pulmonary Disease and Osteoporosis. Resident #19 was discharged from the facility on 1/11/11. The facility was unable to provide documentation by

F202- Documentation for Transfer/Discharge

A. Res. #19 was discharged to home by Dr. Beasley from his office during a follow up ortho. appointment. Res. #19 documentation has been updated in the medical record by our Medical Director to reflect discharge date of 1/11/11.

B. All patients who have outside MD appointments or leave the facility AMA have the potential to be affected by the same deficient practice. Nursing staff and Social Services were in serviced on 7/22/11 and 7/23/11 to ensure that there is a doctor’s order from our Medical Director to discharge every patient, including those who discharge from another MD or who go AMA.
C. When conducting the discharge process, Social Services will monitor discharge information for an appropriate discharge order. Social Services will inform charge nurse of supervisor of any resident who left the facility AMA or who discharged from another MD besides the Medical Director. The charge nurse or nurse supervisor will then provide proper documentation and discharge orders. Upon discharge from the facility, the Medical Record's associate will check for a doctor's order to discharge and inform nursing and Social Services of any discrepancy. Staff will be in serviced on this practice annually and upon date of hire by Nursing Staff Development designee.

D. The medical records associate will check every discharge for a doctor's order and report to nursing department if a discrepancy is found. QA designee will do random audits monthly. Results will be reported to the Medical Director at the QA committee at least quarterly.
## Statement of Deficiencies and Plan of Correction

### Provider/Supplier/Clinical Identification Number:

<table>
<thead>
<tr>
<th>X1 (K1) Provider/Supplier/Clinical Identification Number:</th>
<th>X2 (K2) Multiple Construction</th>
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<tbody>
<tr>
<td>445402</td>
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### Name of Provider or Supplier

Spring Meadows Health Care Center

### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information</th>
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</thead>
</table>
| F 223         | Continued From page 9 anyone, including staff members, other residents... b. 1. Verbal abuse is defined as any use of oral, written or gestured language that includes disparaging and derogatory terms to residents... 2. Physical abuse is defined as hitting, kicking... a. All reports of abuse must be reported to the administrator as well as to the resident's representative (sponsor), within (24) hours of the occurrence of such incident. An immediate investigation must be made and the findings of such investigation must be reported to the administration."
| F 223         | RR #4 requested and was granted 07-25-11 a change in dining room seating on 7-23-2011. Resident #12 had a psychiatric follow up due to an episode of irritability. There have been no further incidents regarding RR #4 and resident #12.

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>X9 Completion Date</th>
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<tbody>
<tr>
<td>F223</td>
<td>RR #4 requested and was granted 07-25-11 a change in dining room seating on 7-23-2011. Resident #12 had a psychiatric follow up due to an episode of irritability. There have been no further incidents regarding RR #4 and resident #12. Social services meet with and interviewed residents #1, 10, 28, and RR #4 regarding resident safety and fear of other residents and/or staff. No reports of current fears of any residents or staff within facility. On 7-22-2011 and 7-23-2011 staff in-serviced and educated on resident rights to be free from verbal, mental, sexual or physical abuse, corporal punishment and involuntary seclusion. Social services will conduct random resident interviews of 10% of current census related to abuse. Staff will be educated and re-educated, by Social Services Director or designee, at hire and yearly in-services on understanding, identifying, reporting and preventing abuse.</td>
<td>07/25/2011</td>
</tr>
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</table>
NAME OF PROVIDER OR SUPPLIER

SPRING MEADOWS HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
220 STATE ROUTE 76
CLARKSVILLE, TN 37043

<table>
<thead>
<tr>
<th>(X1) ID</th>
<th>PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<tbody>
<tr>
<td></td>
<td>445402</td>
<td>A. BUILDING ____________________</td>
<td>07/15/2011</td>
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<td>B. WING _______________________</td>
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<tr>
<th>(X4) ID</th>
<th>PREFIX</th>
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<th>(X5) COMPLETION DATE</th>
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<td>F 223</td>
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Continued From page 10
complains is the one that gets in trouble..."

4. During the group interview, in the activity room
on the new wing, on 7/12/11 at 9:30 AM, Resident 
#1stated, "...[Resident #12] always taunts [RR 
#4] ...they [Resident #12 and RR #4] sit at the 
same table at meals..."

5. Observations in the main dining room on
7/12/11 at 6:55 PM, revealed RR #4 seated at the
inner table with Resident #12. RR #4 stated,
"See, she [Resident #12] sits at the same table
with me and stares at me." RR #4 asked if the
surveyors "had been able to find out anything
about this [indicating that RR #4 had to continue
to sit at the same table with Resident #12]."

Observations in the lobby area across from Nurse
Station 1 on 7/13/11 at 10:30 AM, RR #4 was
seated in the lobby and stated, "Thank you for
looking into this. Do not like to be close to her
[Resident #12] because she might do it [kick me]
again... [Resident #12] Stares at me and I don't
like it."

6. During an interview in Resident #28's room on
7/15/11 at 10:45 AM, Resident #28 stated,
"...when I came back from dialysis I told the
technician I needed to be changed and she said
she would be back. Two hours later I told the
nurse [that he needed to be changed]... and she
[technician] came in and changed me."

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<tr>
<th>F 225</th>
<th>SS=E</th>
<th>483.13(c)(1)(ii)-(iii), (c)(2) - (4)</th>
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INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

The facility must not employ individuals who have
been found guilty of abusing, neglecting, or
mistreating residents by a court of law; or have

C. Social services or designee will
conduct quarterly interviews on
random residents 10% of current
census, regarding abuse. Social
services or designee will report
trends and concerns to the quality
assurance committee.

Social services created and posted
new complaint form on 7-15-2011.
Social services introduced
and explained new form to resident
council on 7-19-2011. Staff was
in-services on new form on 7-22-2011
and 7-23-2011.

Social services created new quality
assurance tool for tracking trends
and will report monthly to quality
assurance committee.

D. Social services or designee will
report to quality assurance
committee quarterly results of
random resident interviews.

Activity director or designee will
report resident council grievances
and concerns to quality assurance
committee monthly.

All supervisors are educated and
timely monitor staff by
observation to ensure no
retaliation to residents.
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 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 record review and interview, it was determined the facility failed to thoroughly investigate all reports of missing items for 6 of 9

A. Social services meet with and interviewed residents # 1, 10, 15, and RR #4 regarding resident rights related to security of surroundings, safety issues, and misappropriation personal property. New inventories of personal property were completed on these residents.

On 7-22-2011 and 7-23-2011 staff in-serviced and educated on resident rights related to security of surroundings, safety issues, and misappropriation of personal property.

B. Social services will conduct random resident interviews of 10% of current census related to misappropriation of personal property.

Staff will be educated and re-educated at hire and yearly in-services by social services or designee on understanding, identifying, reporting and preventing misappropriation of resident's personal property.
C. Social services or designee will conduct quarterly interviews on random residents 10% of current census, regarding misappropriation of personal property. Social services or designee will report trends and concerns to the quality assurance committee.

Social services created and posted new complaint form on 7-15-2011.

The investigation of complaints and trending of complaints will be more thorough. Once the complaint is made, it will be logged on the complaint log with social services. Social services will keep a copy of complaint while pending, and give the appropriate department head the complaint to investigate. The department head will investigate with numerous interviews and will report to social services. Social services will report and document on form date and time, follow up with resident/responsible party, and results or action taken. Then social services will monitor monthly by quality assurance tool which documents trends regarding the increase/decrease of complaints and missing items from month to month. The quality
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| F 225 | Continued From page 13 <br> residents made the following statements: <br> a. Residents #1, 10 and 15 and RR #4, 9 and 10 stated they had problems with missing items in laundry. <br> b. Residents #1, 10 and 15 and RR #4, 9 and 10 stated they had money missing. Residents #1, 15 and RR #9 and 10 stated they had their money in a lock box in their room. <br> c. Resident #15 stated someone had gotten into the lock box while the resident was in the hospital and stole $85. But the facility only replaced $80 because that was the amount they could verify the resident actually had. <br> Reports of investigations of these missing items were not presented to the survey team for review. During interview in the Administrator's office on 7/14/11 at 10:55 PM, the Administrator stated, "knew [named Resident #15] box had been opened. She [Resident #15] left her key when she went to the hospital." <br> 3. During interview in room 38 on 7/12/11 at 3:00 PM, the Social Service Director (SSD) was asked about the reports of missing property. The SSD stated she keeps a log of missing items, reports them to Quality Assurance (QA), but does not trend them according to hall, day of the week or time of day. The SSD stated, she "completes a complaint form on any item reported as missing, but there is no other documentation of an Investigation" other than the Articles Reported Missing form. The SSD stated she had the extra key to the lock box. The SSD could not produce any evidence of resolution as to the missing items. | assurance tool will also trend the wing, shift, date, and resident. Social services will report to quality assurance committee monthly and appropriate department head will address any noticeable trends. 

Social services introduced and explained new form to resident council on 7-19-2011. Staff was inserviced on new form on 7-22-2011 <br>D. Social services or designee will report to quality assurance committee quarterly results of random resident interviews. 

Activity director or designee will report resident council grievances and concerns to quality assurance committee monthly. |
| F 241 | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY | The facility must promote care for residents in a 

A. All signs regarding resident care were removed from rooms of sample residents 3, 5, 6 and random resident 1. |
## SUMMARY STATEMENT OF DEFICIENCIES

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<th>ID</th>
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<td>F 241</td>
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<td>Continued From page 14 manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individually.</td>
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This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation and interview, it was determined the facility failed to change 1 of 1 (Resident #28) sampled resident who remained soiled for 2 hours after he requested to be changed, and failed to protect the dignity of 2 of 25 (Residents #16 and 21) sampled residents and 4 of 12 Random Residents (RR #1, 3, 5 and 6) by putting signs on the wall for anyone to see concerning residents care. Staff failed to knock on the door or receive permission prior to entering RR #2’s rooms and room 74.

The findings included:

1. Medical record review for Resident #28 documented an admission date of 5/23/11 with diagnoses of Affective Surgery, Amputee Below the Knee, Unilateral, Peripheral Vascular Disease, End Stage Renal Disease, Diabetes Mellitus II, Hypothyroidism and Hypertension.

   During an interview in Resident #28’s room on 7/15/11 at 10:45 AM, Resident #28 stated, 
   “...when I came back from dialysis I told the technician I needed to be changed and she said she would be back. Two-hours later I told the nurse and she [technician] came in and changed me.”

2. Observations in Resident #18’s room on 7/11/11 at 4:45 PM, revealed a sign on the wall

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<th>PREFIX</th>
<th>TAG</th>
<th>EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 241</td>
<td></td>
<td></td>
<td>Staff was in-serviced on 7-22-11 and 7-23-2011 to not turn off call light until needs are meet and providing prompt toileting assistance. Staff was in-serviced regarding knocking and receiving permission prior to entering a resident’s room.</td>
</tr>
</tbody>
</table>

B. Social Services or designee will conduct random resident interviews of 10% of current census and identify residents who feel they are not receiving timely call light response for toileting assistance, knocking before entering patient rooms. Social services will report quarterly to quality assurance committee.

C. Staff will be educated upon new hire and yearly in-services on the resident’s rights. Social services or designee will discuss maintaining and enhancing resident dignity, with emphasis on timely response to call light, request for toileting assistance, and knocking prior to entering patient rooms.
<table>
<thead>
<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>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>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 241</td>
<td></td>
<td>Continued From page 15 that documented, &quot;Please keep me pulled up in bed with my head raised so I can breathe.&quot;</td>
<td>F 241</td>
<td></td>
<td>D: Social services or designee will conduct random resident interviews of 10% of current census and report quarterly to quality assurance committee. Social services or designee will conduct quarterly random resident interviews of 10% of current census for 3 months to ascertain if residents are being treated in a manner that maintains and enhances dignity related to call light response time, receiving timely toileting assistance, and knocking prior to entering patient's rooms. Results will be reported monthly to quality assurance committee for the next 3 months and quarterly thereafter.</td>
<td>07-11-11</td>
</tr>
</tbody>
</table>

3. Observations in Resident #21's room on 7/13/11 at 2:00 PM, revealed a sign on the bed that documented, "FLOAT HEELS AT ALL TIMES."

4. Observations in RR #1's room on 7/12/11 4:10 PM, revealed a sign on the wall that documented, "Always put pad in w/c [wheelchair] so cushion does not get soiled."

5. Observations in RR #3's room on 7/11/11 at 10:55 AM, revealed a sign on the wall that documented, "heel protectors at all times. If black boots taken off, it is responsibility of person removing boots to get another form of adequate heel protection."

6. Observations in RR #5's room on 7/11/11 at 10:40 AM, revealed a sign on the wall that documented, "Please pull up in bed after care."

7. Observations in RR #6's room on 7/11/11 at 10:40 AM, revealed a sign over the bed that documented, "Please remember to take me to the toilet prior to laying me down."

8. Observations outside RR #2's room on 7/11/11 at 5:30 PM and on 7/12/11 at 3:00 PM, the Administrator failed to knock or receive permission prior to entering RR #2's room.

9. Observations outside room 74 on 7/11/11 at 5:00 PM, Certified Nursing Assistant #4 failed to knock or receive permission prior to entering room 74.
F 242
SS=D
483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES
The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.

This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure 1 of 25 (Resident #1) sampled residents had the right to make a choice about being transferred from one room to another.

The findings included:
Review of the facility "ADDENDUM RESIDENT RIGHTS" policy documented "...2a. The Resident has the right to receive notice before his or her roommate is to be changed by the Center. 2b. The Resident has the right to refuse to be transferred..."

Medical record review for Resident #1 documented an admission date of 6/5/07 with a readmission date of 3/3/11 with diagnoses of Restless Leg Syndrome, Senile Depression, Hypertension, Osteoarthritis, Gastroesophageal Reflux Disease, Hypothyroidism, Degenerative Joint Disease and Chronic Pain. Review of the Minimum Data Set dated 8/27/11 documented a cognitive score of 15 (indicating being alert and...
Continued From page 17

Orientation: Review of the social progress notes dated 2/23/11 documented, "Res [resident] moved to room 26B @ [at] her request..." There was no documentation of why the resident wanted to move rooms. Review of the social progress notes dated 3/1/11 documented, "Res requesting room change to room 32B..."

Observations in Resident #1's room on 7/11/11 at 11:05 AM, revealed Resident #1 in room 32B.

During an interview in Resident #1's room on 7/14/11 at 6:30 PM, Resident #1 was asked why she transferred from room 35B to room 26B. Resident #1 stated, "I was interfering with patient care... she [resident in 35A] could not speak for herself... they [staff] didn't give me a bath or change her..." Resident #1 was asked why she did not refuse the transfer. Resident #1 stated, "They [staff] told me if I opened my mouth, I would be disciplined..."

During an interview in the east hall on 7/14/11 at 7:53 PM, with the Surveyor, Resident #1 and the Social Worker present, the Social worker listened and wrote down Resident #1's comments about why she was transferred. The Social Worker stated that she did not know why Resident #1 did not discuss this with her before and that the allegations would be investigated.

Social services will report results of quarterly random resident interviews with 10% of current census, to the quality assurance committee.

Since 7-11-2011 the interdisciplinary care plan team has conducted 9 resident care plan meeting with families and residents. From the care plans 5 concerns were expressed, resolved and followed up.

The responsible party and second contact (who meet with the state surveyors in parking lot), of resident #21, were updated on patients condition and all questions have been answered. A care plan meeting has been offered to the responsible party. The responsible party delayed scheduling the care plan until responsible party can coordinate a date for all family members wishing to attend, responsible party will contact facility when date is determined.
Continued From page 18

life in the facility.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation and interview, it was determined the facility failed to communicate adequate response to complaints voiced to administration for 2 of 2 (Residents #21 and 24's family members) family member interviews and 8 of 9 (Residents #1, 10, 14 and 15 and Random Residents (RR) #4, 7, 8, 9 and 10) alert and oriented residents attending the group interview.

The findings included:

1. Medical record review for Resident #21 documented an admission date of 8/8/05 with a readmission date of 3/18/10 with diagnoses of Hyperkalemia, Acute Renal Failure, Urinary Tract Infection, Vascular Dementia with Depression, Osteoporosis, Diabetes Mellitus, Dehydration, Neuropathy and Anemia. Review of the physician's progress note dated 4/21/11, documented "[name of physician] made aware of [upper] pulmonary lesion..."

During a family member interview in the parking lot of the facility on 7/11/11 at 6:40 PM, Resident #21's family member stated that she had concerns that the facility staff wouldn't tell her about her mother's wounds.

During an interview in Resident #21's room on 7/13/11 at 2:00 PM, the Responsible Party stated, "...nobody has told us what the growth is... this cough has to be connected to this growth... if"

On 7-17-2011 resident #24 expired.

On 7-22-2011 and 7-23-2011 staff was in-serviced and educated on resident rights and the facilities responsibilities to communicate changes of condition to the responsible parties of all residents and to act upon all grievances and recommendations. The responsible parties and residents will also be informed of the result/outcome of the complaint.

On 7-18-2011 social services meet with resident council with their authorization, to inform of resident rights relating to resident complaints. Social services gave a copy of new complaint form to each resident in attendance. Social services explained complaint process regarding complaint resolution; all residents voiced understanding of rights and process.

On 7-15-2011 a new complaint form was created and posted in the facility. The new form's investigation process includes interviewing numerous sources and creating a documentation space for date and time of follow up.
**Spring Meadows Health Care Center**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)</th>
</tr>
</thead>
</table>
| F244 | Continued From page 19 | she's [Resident #21] in pain... do we need to call hospice... don't know what to do...

2. Medical record review for Resident #24 documented an admission date of 1/16/07 with a readmission date of 8/30/10 with diagnoses of Cerebral Ataxia, Insomnia and Gastric Reflux Disease. Review of the physician's progress note dated 4/28/11 at 9:00 AM documented "...they [family] do not want to prolong her life with antibiotic treatment, but do want her to remain comfortable. We agreed to focus treatment on symptoms..." Review of the "Event Documentation" dated 6/8/11 at 7:00 PM, documented "...Actions / Interventions... 2 person staff assist transfer and the need for support due to functional impairments..." Review of the "NUTRITIONALLY AT RISK [NAR] RESIDENT WORKSHEET" dated 6/22/11 documented "...Resident is expected to continue to decline as part of disease process..." Review of the current "NA [Nurse Assistant] Care Plan Record" documented "...Mobility/Transfer... Assist X [times] 2... Maxi/Hoyer Lift X 2... Bath... Total... Hair Wash... Staff... Special Needs... Do not turn off call light until her needs are met... Diet... Total Feed—Do not deliver tray until you are ready to feed her... Dressing/Grooming... Total Assist..."

Observations in Resident #24's room on 7/14/11 at 9:22 AM, revealed Resident #24 lying in bed on her back with her eyes open and a press pad call light under her hand. Resident #24 did not respond verbally or physically to questions asked and did not push call light when asked to do so by the surveyor. Resident #24's eyes moved slightly back and forth, but no other response was observed.

**B.** Social services or designee will conduct random resident interviews of 10% of current census. Social services will identify areas of concern and report results quarterly to quality assurance committee. Areas of concern will be investigated and appropriate action taken.

**C.** Social services or designee will educate staff of upon hire and yearly in-service regarding the resident's rights to have complaints heard and addressed.

Social services or designee will conduct random resident interviews of 10% of current census and report quarterly to quality assurance committee.

Care plan meetings will be offered to all families and cognitive residents. Concerns will be addressed and the responsible party and resident will receive a response to the grievance. All responsible parties and residents will be encouraged to use a
During a family member interview in room 38 on 7/14/11 at 8:03 AM, Resident #24's son expressed his concerns to the survey team about the facility's lack of care for his mother, the administration's lack of investigation into his concerns and the lack of information he was given as to why his mother was not receiving adequate care. He acknowledged his mother's physical and mental decline to care for herself and her increasing dependence on others for her basic needs. Resident #24's son stated that when his mother pushed the call light, the staff would often, "...hit the button [reset]... 90 percent of the time we would be told that they would be right back... they would do this [push the reset button] several times... again we would hit the call light again." Resident #24's son stated that his mother would "...lie in bed with pads and sheets soaked on a daily basis." Resident #24's son stated that he has repeatedly discussed his concerns with the administration of the facility. Resident #24's son stated that in these discussions "...we mean, we beg and we plead, but nothing ever happens... I complain that mom's not getting the proper care... I have sat down with [named Administrator and Director of Nursing]..." Resident #24's son stated the Administrator's responded, "...we meet the minimum state standards..." and that if Resident #24's family did not like the care the facility provided, they "...could go to another nursing home." Resident #24's son stated, "...I lost hope when I didn't get any results..."

3. Observations in Resident #1's room on 7/11/11 at 11:05 AM and 4:20 PM, on 7/12/11 at 8:20 PM and on 7/15/11 at 10:55 AM, revealed a complaint form and return it to the appropriate department. All complaints will be investigated and appropriate staff will follow up with the responsible party and cognitive resident regarding the appropriate action taken.

Staff was in-serviced on 7-22-2011 and 7-23-2011 to answer call lights promptly and not turn light off until addressing the need. All staff will also be in-serviced on call light response time, communication with families and residents at hire and yearly in-service. Charge nurses and supervisors will do daily rounds on each shift to ensure call lights are answered in a timely manner.

Quality assurance and social services will maintain a grievance/complaint log with investigations and follow up results and will communicate the response to the cognitive patient and responsible party.
<table>
<thead>
<tr>
<th>F 244</th>
<th>Continued From page 21</th>
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<tbody>
<tr>
<td></td>
<td>hole in the bathroom door, paint and dry wall chipped from the wall in the bathroom, a black substance on the wall of the bathroom and around the base boards of the room and a broken cover for the air conditioner.</td>
</tr>
</tbody>
</table>

During an interview in Resident #1's room on 7/11/11 at 11:05 AM, Resident #1 was asked if she had reported the conditions noted above to anyone in the facility. Resident #1 stated that she had told the Administrator and that his response was, "What do you want me to do about it?"

During the a group interview, in the activity room on the new wing, on 7/12/11 at 9:30 AM, the surveyor asked if the facility listened to suggestions or complaints made by individual residents or the resident council. Resident #1 stated, "...they listen to you but don't do anything about it or get back with you..."

During an interview in the main hall on 7/15/11 at 10:30 AM, Resident #1 stated, "...going to tell the Administrator that my toilet is running and there is water on the floor... it does this every day..."

During an interview in Resident #1's room on 7/16/11 at 10:55 AM, Resident #1 stated, "...told the Administrator and his response was that he would be down in a minute... afraid to go to the bathroom because of the water on the floor... can you tell them to hurry up... I have to go to the bathroom..."

4. During the group interview, in the activity room on the new wing, on 7/12/11 at 9:30 AM, the alert and oriented residents made the following statements, after they were asked if they could

<table>
<thead>
<tr>
<th>F 244</th>
<th>Social services or designee will conduct random resident interviews 10% of current census and report quarterly to quality assurance committee.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Activities department will report resident council complaints monthly to quality assurance committee.</td>
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<tr>
<td></td>
<td>The DON designee will do weekly audits to ensure that grievances have been acted upon and communicate to the responsible party and cognitive resident that the appropriate actions have been taken.</td>
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<tr>
<td></td>
<td>Call light response time will be monitored weekly using the RSW software system. Any staff found to be deficient in the practice will be counseled by a supervisor or the DON designee.</td>
</tr>
<tr>
<td></td>
<td>All grievances and the results will be discussed by the quality assurance committee at least quarterly. The Human Resource Director will monitor through existing corporate compliance program, any reported unresolved concerns regarding administration failure to resolve and follow up any grievances.</td>
</tr>
</tbody>
</table>
Continued From page 22

voice concerns to the staff:

a. Resident #10 stated, "...they apply the rules and regulations when they want to..." and that "...the one that complains is the one that gets in trouble..." Residents #1, 10, 14 and 16 and Random Residents (RR) #4, 7, 8, 9 and 10 stated they feel free to talk to the facility staff and administration, but the staff do not listen to the residents or keep them informed of any results from their concerns.

b. Resident #15 stated, "...they don't tell you anything here..." The surveyor asked how the administration responds to concerns voiced by residents. RR #9 stated, "...they don't get back with you as to the process or where it is in the process... they do not listen to you ...DON [Director of Nursing] doesn't listen..."

5. During an interview in room 38 on 7/12/11 at 3:58 PM, the social worker was asked how the facility investigates missing personal property and how they keep residents informed of the progress of the investigation. The Social Worker stated, "...get housekeeping to do a search for the item... give it [concerns] to [named Administrator], they [residents] can go to him [Administrator]... we can't be responsible for all their personal items..."

6. During an interview in the Administrator's office on 7/14/11 at 10:55 PM, the Administrator was told of the concerns expressed by the residents during the group interview. The Administrator stated, "...their [residents] perception is if they don't get the answer they want... often come in and complain about staff and want them fired..." The Administrator was asked if he gets back with the residents after they have voiced their concerns. The Administrator
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
<thead>
<tr>
<th>Provider/Supplier/Clinical Identification Number:</th>
<th>(x1) Provider/Supplier/Clinical Identification Number:</th>
<th>(x2) Multiple Construction</th>
<th>(x3) Date Survey Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>445402</td>
<td></td>
<td></td>
<td>07/15/2011</td>
</tr>
</tbody>
</table>

**Name of Provider or Supplier:**

**Spring Meadows Health Care Center**

**Street Address, City, State, Zip Code:**

228 State Route 76
CLARKSVILLE, TN 37043

<table>
<thead>
<tr>
<th>ID/Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LEC 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>
</tr>
</thead>
<tbody>
<tr>
<td>F 244</td>
<td>Continued From page 23 stated, &quot;not always.&quot;</td>
<td>F 244</td>
<td></td>
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</tr>
<tr>
<td>F 246 SS-E</td>
<td>483.15(e)(1) Reasonable Accommodation of Needs/PREFERENCES</td>
<td>F 246</td>
<td>7/23/11</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A. Resident #24 D/C from facility on 07/17/11.</td>
<td></td>
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<tr>
<td></td>
<td>Resident #1, #15 &amp; #28; Resident #1 Care Plan meeting on 07/20/11; No</td>
<td></td>
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<tr>
<td></td>
<td>concerns voiced regarding call light response time or fresh ice water. Resident #15</td>
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<tr>
<td></td>
<td>schedule Care Plan meeting on 07/29/11 @10:30.</td>
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</tbody>
</table>

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation and interview, it was determined the facility failed to accommodate each residents' needs by failing to answer call lights timely, failing to respond to a resident's need when the call light was answered or failed to ensure there was fresh/ice water at each residents' bedside for 4 of 25 (Residents #1, 15, 24 and 28) sampled residents observed and for 33 of 98 residents.

The findings included:

1. Random observations during the initial tour of the facility on 7/11/11 starting at 10:30 AM, revealed 33 of 98 residents did not have ice water at their bedside.
2. During an interview in Resident #1's room on 7/11/11 at 10:30 AM, Resident #1 stated, "You have to ask for fresh water..." During the snack tour on 7/12/11 at 8:46 PM, Resident #1 requested ice water.
3. During the snack tour on 7/12/11 at 8:46 PM, Resident #15 requested ice water.
4. Observations in the main dining room on 7/12/11 at 3:00 PM, revealed 12 of 22 tables that
Continued From page 24

5. During an interview in Resident #1's room on 7/11/11 at 10:30 AM, Resident #1 stated, "...there is a lengthy wait to have call lights answered... sometimes 2 hours [before call light is answered]..."

6. During a family member interview in room 38 on 7/14/11 at 8:03 AM, Resident #24's son stated that when his mother pushed the call light, the staff would often, "...hit the button [reset]..." 90 percent of the time we would be told that they would be right back... they would do this [push the reset button] several times... again we would hit the call light again..." Resident #24's son stated that his mother would "...lie in bed with peds and sheets soaked on a daily basis..." Resident #24's son stated that he has repeatedly discussed his concerns with the administration of the facility.

Residents #24's son stated that in these discussions "...we moan, we beg and we plead, but nothing ever happens... I complain that mom's not getting the proper care... I have sat down with [named Administrator and Director of Nursing],..." Resident #24's son stated the Administrator's responded, "...we meet the minimum state standards..." and that if Resident #24's family did not like the care the facility provided, they "...could go to another nursing home..." Resident #24's son stated, "...I lost hope when I didn't get any results..."

7. Medical record review for Resident #28 documented an admission date of 5/23/11 with diagnoses of Aftercare Surgery, Amputee Below the Knee, unilateral, Peripheral Vascular Disease, End Stage Renal Disease, Diabetes Mellitus II, Hypothyroidism and Hypertension.

| F 246 | B. H20/Ice pass form implemented to identify all residents have H20/Ice passed @ bedside every shift. Social Services will interview Random Residents (10% of current census/quarterly) to ensure this need is met and report results to QA Committee.

* Dietary Department to maintain ice/H20 & Iced Tea in freezer with lids until ready to serve to prevent from melting.

| C. All staff in-serviced on 07/22/11 & 07/23/11, upon hire & annually by Nursing Staff Development designee, regarding call light response time & H20/Ice pass every shift & per Resident request with exceptions of NPO residents & fluid restricted residents. All staff in-serviced to leave call light on until needs are met.

* Residents returning from appt. will be assessed by charge nurse upon return to facility.
### F 246

Continued From page 25

During an interview in Resident #28's room on 7/11/11 beginning at 10:30 AM, Resident #28 stated, "I push the call button. They [staff] come in 2 hours later. They [staff] pull the call button out of the wall..."

During an interview in Resident #28's room on 7/15/11 at 10:48 AM, Resident #28 stated, "...It takes [staff] too long to answer call lights. Longest waited 2 hours and next 1 hour. A tech [technician] came in when I came back from dialysis. I needed to be changed. She [technician] said she would be back and came back 2 hours later when I told a nurse... Sometimes I ask them [staff] to get me up in wheelchair to eat. She [technician] said she did not have time. I can eat better when I am up."

D. Ward clerk will audit Ice pass flow record daily.

* Charge Nurse compliance round daily to include follow up, daily check of ice/I20.

* B.O.N. and/or designee will do monthly record audits to maintain compliance. Results of audits will be reported by the QA Nurse in the QA Committee Meetings at least quarterly. All nursing supervisors are educated and will monitor daily, by direct observation, ice water in resident's rooms. Dietary manager will observe and monitor dining room daily for ice in tea or water.

### F 253

483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:

Based on observation and interview, it was determined facility failed to ensure housekeeping and maintenance maintained a clean and sanitary environment as evidenced by holes in doors, paint chipping on walls, black substances on the walls, loose and buckled molding, a cover over an air conditioner control was missing, a commode running over and/or dried brown substance splattered on the walls, baseboards and floors in 13 of 69 (resident rooms 22, 23, 24, 25, 26, 27, 28, 37, 39, 40, 41, 32 and 69) resident rooms.
**Continued From page 26**

The findings included:

1. Observations of the facility during the initial tour on 7/11/11 beginning at 10:30 AM revealed the following:
   a. Room 22 - Door and bathroom door chipped. Cord hanging on floor. Outlet plate off the wall. Light flickering.
   b. Room 23 - Door and bathroom door chipped. Bathroom rail loose.
   c. Room 24 - Door trim scuffed/marked and chipped. Bathroom rail loose.
   e. Room 26 - Door chipped. Wall between beds has gash out of plaster. Bathroom hand rail loose.
   g. Room 28 - Door frame chipped. Air conditioner unplugged, cord laying in floor.
   h. Room 37 - Door scuffed/markd.
   i. Room 39 - Door scuffed/markd up. Hot water handle on bathroom facet turned the wrong way.
   k. Room 41 - Door and frame chipped. Walls have plaster patches.

2. Observations in room 32 on 7/11/11 at 11:40 AM, revealed a hole beside the outside knob of the bathroom, paint chipped on bathroom wall, a black substance on the bathroom wall and around the molding leading to the bathroom, molding around bottom of wall loose and buckled, cover of air conditioning control was missing.

3. During an interview in the main hall on 7/15/11 at 10:30 AM, Resident #1 stated, "going to tell the Administrator that my toilet is running and..."

<table>
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<tbody>
<tr>
<td>F253</td>
<td></td>
<td><strong>A.</strong> a. Repaired door and bathroom door, outlet plate and light.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Door and bathroom door repaired, rail tightened.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. Door trim painted, rail tightened.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>d. Door frame, bathroom door &amp; rail repaired.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>e. Door and plaster repaired, hand rail fixed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>f. Door frame &amp; door painted, hand rail repaired.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>g. Door and cord repaired.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>h. Door Painted.                                                  <strong>7/27/11</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>i. Door painted &amp; bathroom faucet reversed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>j. Door repaired.                                                 <strong>F253</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>k. Door frame repaired, dry plaster sanded &amp; repaired.</td>
</tr>
</tbody>
</table>

2-3. Temporarily relocated resident, with her consent, to repair & repaint entire room.
F 253  Continued From page 27
there is water on the floor... it does this every
day..."

During an interview in Resident #1's room on
7/13/11 at 10:55 AM, Resident #1 stated, "...told
the Administrator and his response was that he
would be down in a minute... afraid to go to the
bathroom because of the water on the floor... can
you tell them to hurry up... I have to go to the
bathroom..."

4. Observations in room 69 on 7/12/11 at 4:00
PM, revealed a dried brown substance splattered
on the walls, baseboards and floors.

F 257
483.15(h)(6) COMFORTABLE & SAFE
TEMPERATURE LEVELS

The facility must provide comfortable and safe
temperature levels. Facilities initially certified
after October 1, 1990 must maintain a
temperature range of 71 - 81° F

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was
determined the facility failed to maintain a
comfortable room air temperature of 71 to (-) 81
degrees Fahrenheit (F) in 1 of 2 (main dining
room) dining rooms.

The findings included:
1. During the group interview, in the activity room
on the new wing, on 7/12/11 at 9:30 AM, Resident
#10 and RR #4 stated the dining room is hot all
the time.

4. Room is regularly cleaned
twice daily due to Residents
choice of chewing tobacco
and spitting carelessly.
Special attention was given
to dried, brown tobacco
spittle on walls, baseboards,
and floors on 07/18/11.

B. All patient rooms will be
audited by staff to identify
holes in doors, chipping
paint, missing A/C control
covers, and running toilets.
Maintenance will prioritize
list and address
accordingly.

C. In addition to repairing
items identified on
Maintenance Request
Forms, Maintenance
Department will audit
patient rooms one wing
per month, and make repairs as
necessary.

D. Maintenance Director and
Administrator will monitor
monthly for compliance.
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
</table>
| F 257 | Continued From page 28  
2. Observations in the main dining room on 7/12/11 at 6:00 PM, revealed Resident #10, Random Resident (RR) #4, RR #8 and RR #11 had very red cheeks.  
During an interview in the main dining room on 7/12/11 at 8:00 PM, RR #4 stated "It's hot in here [main dining room]."  
3. Observations in the main dining room on 7/12/11, with the surveyor's thermometer, the following room air temperatures were obtained:  
a. At 6:00 PM, the east side of the dining room was 84 degrees F.  
b. At 6:15 PM, the dining room was 87 degrees F.  
c. At 6:15 PM, the west side of the dining room was 88 degrees F.  
4. During an interview in the dining room on 7/12/11 at 6:10 PM, the Administrator was shown the air conditioner units with loose casings putting out small amount of air when set on high. The administrator stated, "...they [air conditioners] are doing all they can do... could be frozen up..."  
During an interview outside the social workers office on 7/12/11 at 9:30 PM, the Administrator was asked what he was going to do about the air conditioners in the main dining room. The Administrator stated, "Until the other serviced, don't know what we will do. If it's hot tomorrow, residents will eat in their rooms..." | F 257  
7/12/11  

A. 1-4 All seven PTAC units in the Dining Room were checked. Two were replaced on 07/12/11. Temperature is maintained in Dining Room between 75.2 and 77.5  
B. All other PTAC units in building were checked and serviced as required to ensure acceptable temperature is maintained.  
C. During air conditioning season, all units will be checked weekly and serviced or replace if needed.  
D. Maintenance Director and Administrator will monitor monthly. Maintenance director or Administrator will monitor and check temp. in the dining room daily during A/C season.  

F 278  
SS=D  
483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  
The assessment must accurately reflect the resident's status.  

7/12/11  

If continuation sheet Page 29 of 83
F 278 Continued From page 29

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.

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 ensure the Minimum Data Set (MDS) was accurate for cognition and dialysis for 2 of 31 (Residents #9 and 14) sampled residents.

The findings included:
1. Medical record review for Resident #9
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>Summary Statement of Deficiencies</th>
<th>ID</th>
<th>Tag</th>
<th>Provider's Plan of Correction</th>
</tr>
</thead>
</table>
| F 278 | Continued from page 30 documented an admission date of 2/14/05 with diagnosis of Diabetes Mellitus, Dementia, Anxiety, Hypertension (HTN) and Osteoporosis. Review of Resident #9's annual MDS dated 10/22/10 indicated resident is rarely/never understood. During an interview in the MDS Coordinator's office on 7/14/11 at 12:10 PM, Nurse #10 stated, "...that [MDS] would be incorrect on the annual, she [Resident #9] is very interviewable and can answer all questions correctly and she is very alert..."

2. Medical record review for Resident #14 documented an admission date of 1/21/11 with diagnosis of End Stage Renal Disease, Dialysis, Fractured Tibia, Diabetes Mellitus and HTN. Review of Resident #14's admission MDS dated 2/21/11 was not coded for dialysis treatment.

During an interview in Resident #14's room on 7/13/11 at 4:30 PM, Resident #14 was asked how long he has been receiving dialysis treatments. Resident #14 stated, "...have been on dialysis for 4 years..."

During an interview in the MDS Coordinator's office on 7/14/11 at 2:10 PM, Nurse #10 was asked if Resident #14 was on dialysis upon admission. Nurse #10 stated, "...[MDS] does not have anything for dialysis, has been on dialysis for 4 years..."

| F 280 | SS-J | 483.20(d)(3), 483.10(k)(2) Right to Participate Planning Care-Revise CP | F 280 | 

The resident has the right, unless adjudged incompetent or otherwise found to be...
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

445402

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
07/15/2011

NAME OF PROVIDER OR SUPPLIER
SPRING MEADOWS HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
220 STATE ROUTE 76
CLARKSVILLE, TN 37043

(X4) ID PREFIX TAG [SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)]

F 280 Continued From page 31
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 by:
Based on review of the event documentation forms, medical record review, observation and interview, it was determined the facility failed to ensure interventions were developed after each fall for 2 of 20 (Residents #3 and 8) sampled residents identified with falls. Resident #3 was assessed as being at risk for falls. Resident #3 sustained eight falls from 2/3/11 to 7/14/11, there were no new intervention developed to prevent further falls or injuries from falls for seven of those falls. Five falls resulted in serious injuries such as lacerations with sutures, one fall sustained a chipped tooth and the fall on 7/4/11 resulted in a fractured nose. The facility’s failure to develop interventions to protect the resident after each of these falls placed Resident #3 in

F 280

7/14/11 F280

A. Immediately after each fall, resident is assessed and treated for any injuries. Nurse will try to determine root cause, address individual needs, initiate Bowel and Bladder Assessment, complete Fall Risk Assessment and implement appropriate interventions per Standard Operating Procedure for Falls. Resident is also placed on Falling Star Program after initial fall.
Res. #3 – 1:1 Nurse aide began immediately at 1:00pm on 07/14/11 for 30 days to observe B & B patterning, bed and w/c exit attempts and identify possible causes. Will re-evaluate after 30 days and plan accordingly.

- Order obtained from physician for P/T eval for seating device.
- Drop seat w/c provided by P/T.
- Reverse Torso Support while up in chair.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**X1 PROVIDER/SUPPLIER/CICA IDENTIFICATION NUMBER:** 445402

**X2 MULTIPLE CONSTRUCTION**
- **A. BUILDING:**
- **B. WING:**

**X3 DATE SURVEY COMPLETED:** 07/15/2011

**X4 ID TAG**

<table>
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<tr>
<th>ID</th>
<th>TAG</th>
<th>PROVIDER’S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 280</td>
<td>Continued From page 32</td>
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</tbody>
</table>

**A**.

**B.**

- **Installed Smart Alarm Sensor**
- **New fall risk assessment done and Care Plan updated.**
- **All patients at risk for falls will be re-assessed by P/T to ensure devices in use are effective and appropriate on 07/14/11.**

Resident #8 had fall risk assessment done on 07/14/11 and had 1:1 supervision X 24 hrs. with no w/c or bed exit attempts identified. P/T screened on 07/14/11 to ensure proper devices were in place and recommended ambulation 2 X per day with rolling walker and 2 person assist.

**B.** New fall risk assessments were done on all patients on 07/14/11.

- **Audit of fall risk assessment to identify that assessments are completed upon admission, quarterly, and after each fall.**
- **Identify patients who are Falling Stars on each shift’s CNA assignment sheet to increase their awareness of those identified at risk.**
F 280 Continued from page 33

was heard in Res [Resident] room CNA [Certified Nurse Assistant] … went to get alarm & [and] found Res face down on floor, blood under her head. CNA called this nurse to room … LPN [Licensed Practical Nurse] also came to Res room. Pressure was applied to site on (R) [Right] side of forehead. Gash approximated @ [at] 1 1/2 to 2 inches in length. Res had blood coming from (R) nostril. 911 was called…

Nurse's notes further documented the resident was returned to the facility the same day with sutures to the right forehead.

Review of Resident #3's care plan for risk for falls revealed handwritten interventions of, "2/13/11, Fall; Medical Management Add alarming w/c [wheelchair] Pressure mat" were added to the care plan. "Under seat alarm" was previously listed as an intervention on this care plan for Resident #3. No new intervention was developed after this fall.

b. Review of Resident #3's nurse's notes dated 3/11/11 at 2:00 AM documented, "Resident called for help. Upon entering room found resident lying beside bed (in lowest position) c [with] blankets in hand. No c/o's [complaints] verbalized... No injuries apparent."

Review of Resident #3's care plan for risk for falls revealed no new intervention was developed after this fall.

c. Review of Resident #3's nurse's notes dated 3/14/11 at 4:30 PM documented, "CNA heard resident moaning, walked into rm [room] found resident laying face down on the floor on left side of bed. Resident [resident] cut (L) [left] forehead,

- P/T screening after each fall within 72 hours.
- Re-enforce Falling Star Program through in-service.
- Follow Standard Operating Procedure for Falls.
- Within one week the team will network with our resources within the association and our sister facility to get ideas on successful strategies for preventing and dealing with resident falls.

C. On 07/14/11 the CNA doing 1:1 was educated as to exactly why she was doing 1:1 with Resident #3 (to observe bed and w/c exit attempts, B&B patterning, and other possible causes).

3-11 and 11-7 shift staff was in-serviced by the Administrator on Falling Star Program and have the patients at risk pointed out to them on their assignment sheets. All 7-3 shift, weekend shifts, and personnel off duty were in-serviced upon their next working shift.
<table>
<thead>
<tr>
<th>ID_tag</th>
<th>ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)</th>
<th>PROVIDER'S PLAN OF CORRECTION (Each corrective action should be cross-referenced to the appropriate regulatory/section)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
</table>
| F.280  | F 280     |     | Continued From page 34 glasses broke, large puddle of blood noted. Incision cleaned, sterile strips applied. Hospice nurse to come eval [evaluate]. Subsequent nurse's notes documented the hospice nurse visited; the resident was transferred to the Emergency Room via ambulance and returned to the facility after having a CT [Computerized Tomography] scan of the head and receiving 7 sutures to the left forehead. The nurse's notes dated 3/14/11 documented, "Large amount of edema et [and] discoloration noted to entire (L) orbital area." Review of Resident #3's care plan for risk for falls revealed a handwritten intervention added, "3/14/11, Add Grey floor Pressure mat to prevent injury." This care plan already documented "Lowbed with mats on floor." No new intervention was developed after this fall. d. Review of the nurse's notes dated 6/10/11 at 1:30 AM documented, "This nurse was called to Room (#) where Res was laying on the floor face up, on her back... LPN was applying pressure to wound [upper] (R) [right] eye to stop the bleeding of the open area. The area & (R) side of Res face was purple in color, edematous [edematous] ...911 was called ...transferred via ambulance..." Nurse's notes documented the resident was sent to the Emergency Room and returned with sutures above the Right eye. The event documentation form dated 6/10/11 documented types of injury sustained included laceration, hematoma, skin tear and chipped front tooth. Review of Resident #3's care plan for risk for falls had previous falls and how many for the past 180 days. Nursing and CNA Care Plans will be updated to reflect changes in interventions. Nursing documentation X 3 days after fall will be reviewed for implementation, effectiveness, and appropriateness.

- We will audit Fall Risk Assessments to ensure they are done timely upon admission, quarterly, and after each fall.
- All staff will be in-serviced by D.O.N. or supervisor upon hire, annually, and as necessary with Falling Star Policy and Procedure.
- Fall Risk Committee will meet weekly in separate meeting to review incidents of falls and implement appropriate interventions/devices. Falls Risk Committee consists of O/T, P/T, MDS, Restorative CNA and QA Nurse. Weekly this committee will address every fall and evaluate devices and the effectiveness of interventions. And meeting will documented in QA Fall Team Minutes. All falls will continue to be reviewed and addressed every morning at which time we will review incident documentation, devices used, effectiveness and appropriateness. We will check to see if resident has
Continued From page 35
revealed a handwritten intervention added, "6/10/11, Fall; Floor mat alarm." This care plan also included an intervention of "Floor pressure sensitive alarm"; a single line was drawn through the intervention and "D/C [discontinue]" was written beside the intervention. There was no date documented for discontinuing this intervention and there was no new intervention developed after this fall.
e. Review of the nurse's notes dated 6/12/11 at 11:30 AM, documented, "CNA reports that she heard alarm & entered Rm (9) & noted resident on floor on (L) side in front of WC & recliner. Denies pain or discomfort. No injuries..."

The event documentation form dated 6/12/11 documented, "Actions / Interventions" to be implemented were "Medical management - (UA [urinalysis] C&S [culture and sensitivity]) - per fall team," Laboratory (lab) reports reviewed revealed a urinalysis on 6/14/11 was negative and a urine culture collected 6/14/11 showed no growth. There was no documentation the lab results had been reviewed by the fall team, or any additional interventions had been attempted after the lab results were received.

Review of Resident #3's care plan for risk for falls revealed an intervention added, "6/12/11, Fall; Medical mgmt [management]." This was not a new intervention and was not specific of what staff were to do to prevent injuries from falls.
f. Review of the nurse's notes dated 6/14/11 at 12:00 PM documented, "This nurse called to resident's room per CNA - upon entering room noted resident lying on floor beside roommate's
### Continued From page 36

**Bed-prone position - resident states, "I got out w/c to go to BR [bathroom]" - chair alarms were in place - upon assessment noted a moderate amt [amount] sanguineous [bloody] drainage on floor noted (3) lacerations forehead, noted open area bridge of nose - noted [upper] lip sl [slightly] swollen - resident c/o [complaint] HA [headache]." Subsequent notes documented the resident was sent to the ER [emergency room] and returned with sutures to the left eyebrow, bridge of nose and left forehead.**

Review of Resident #3's care plan for risk for falls revealed a handwritten intervention added, "6/14/11, Fall; Redirect to social area or back to DR [dining room] during meals." The care plan documented interventions of, "Except for bed and bathroom times keep resident in lobby for observation." This intervention was not specific of what staff were to do to prevent injuries from falls.

g. Review of the nurse's notes dated 7/4/11 at 3:00 PM documented, "This nurse called to resident's room per CNA - upon entering room noted resident lying on floor - face down - [moderate] amt [amount] blood noted on floor forehead states, 'I fell' ....to ER..." Subsequent nurse's notes revealed a CT of the head revealed a nasal fracture and the resident received sutures before returning to the facility.

Review of the care plan for risk for falls revealed interventions, "7/4/11, Fall; Medical management." This was not a new intervention and was not specific of what staff were to do to prevent injuries from falls.

Observations in Resident #3's room on 7/11/11 at
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CILA
IDENTIFICATION NUMBER:

446402

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

B. WING

(X3) DATE SURVEY
COMPLETED

07/15/2011

NAME OF PROVIDER OR SUPPLIER

SPRING MEADOWS HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

220 STATE ROUTE 76

CLARKSVILLE, TN 37043

(X4) ID
PREFIX
TAG

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

F 280: Continued From page 37
11:18 AM, revealed Resident #3 in bed with dark brown eschar on her forehead, nose and chin and greenish-yellow discoloration to the right cheek. Resident #3 was receiving oxygen via binalas cannula at 2 liters a minute. Floor mats were observed on both sides of the very low bed, and falling star signs were on the foot of the bed and the door frame. A w/c was parked at the foot of the bed with a seat sensor and portable oxygen tank attached.

During an interview with the fall team on 7/14/11 at 10:55 AM to 12:00 PM, the Director of Nurses (DON) was asked what interventions were in place to prevent falls for Resident #3. The DON stated, "...not trying to prevent her falls, just trying to prevent her injuries." The DON stated, "She [Resident #3] knows how to beat the alarms, when she had pressure chair alarms before, she knew to put a book in the chair so the alarm would not sound when she stood... She [Resident #3] had no falls from 11/29/09 until 2011. Every 90 days with no fall, we take away one intervention; we try to decrease an intervention every 90 days... Short of restraining her [Resident #3], it is difficult to prevent falls, she has the right to fall... They [indicating the federal surveyor from Centers for Medicare and Medicaid Services [CMS] present in the meeting] say she has the right to fall... Out of a hundred or so residents, she [Resident #3] is an isolated case. Alarms work more effectively on some than on others, we move from one alarm to another and revisit them quarterly and/or with falls. We have a lot of new and innovative interventions. We feel [Resident #3] is a very unique case and is looked at over the years. She [Resident #3] went a year without a fall and I'm very pleased."

F 280
Resident #3 sustained eight falls from 2/13/11 to 7/4/11. Five falls resulted in lacerations that required sutures; she sustained a chipped tooth on 6/14/11 and a fractured nose on 7/4/11. The facility's failure to develop interventions to protect the resident after each of these falls placed Resident #3 in immediate jeopardy as evidenced by serious injuries that required medical interventions.

Observations in Resident #3's room on 7/15/11 at 8:30 AM revealed Resident #3 was in her w/c at bedside, being fed breakfast by CNA #5. Resident #3 was noted to have a reverse torso support in place. At 9:30 AM, Resident #3 was observed in bed in her room, CNA #5 was seated at bedside.

During an interview in Resident #3's room on 7/15/11 at 9:35 AM, CNA #5 stated her assignment for that shift was to provide 1 on 1 care for Resident #3, document Resident #3's toileting concerns each hour and document any attempts to exit the bed or the w/c. CNA #5 stated she was told someone will be assigned to the resident for 30 days.

During an interview at the #1 Nursing Station on 7/15/11 at 9:40 AM, Nurse #5 stated, "1:1 supervision will be continued 30 days and re-evaluated until we know she is safe at the highest level of functioning."

The immediate jeopardy was identified on 7/14/11, was lifted on 7/15/11 at 5:05 PM and noncompliance continues at the lower scope and severity level of D. Refer to F323.
F 280 Continued From page 39

2. Medical record review for Resident #8 documented, an admission date of 4/1/11 and a readmission date of 7/1/11 with diagnoses of Diabetes Mellitus, Hyperlipidemia, Senile Delusions, Dementia with Behavior, Anxiety, Alzheimer's, Hypertension, Seizures and Depression. Review of the nurse's notes dated 4/2/11 at 1:00 PM documented, "...Resident up C&B [cut of bed] for meal. Ambulate per self and ad lib [at liberty]... 5/20/11 11 AM ...Resident [symbol for up] ambulating in hallway, 6/4/11 4:15 PM ...Resident has been unsteady on his feet..." Review of the nurse's notes dated 6/18/11 at 4:00 PM documented, "Resident stood up from W/C and fell backwards over back of the chair, hitting his head and shoulders first. Resident was unconscious X [times] 30 sec [seconds] to 1 min. [minute] Remained semi-conscious X 20 min... send to ER evaluation and treatment..." Review of the "Progress Note - Psychiatric ...Date: 7/14/11... Flu [follow-up] readmission to facility 7/11/11 s/p [status post] intracranial hemorrhage [hemorrhage]..." Review of the care plan dated 9/19/11 documented, "...Risk for fall ...6-18-11 Fall, Medical Management..." The care plan was not specific with what medical management interventions were to prevent injuries from falls.

Observations in the Old Wing TV room on 7/12/11 at 7:40 AM, revealed Resident #8 seated in wheelchair.

Observations in the TV room on the New Wing on 7/14/11 at 7:00 PM, revealed Resident #8 seated in a wheelchair with ear buds on. Smiling and appears to be moving with the music from the iPod.
During an interview with the fall team on 7/14/11 at 10:55 AM to 12:00 PM, when asked when Resident #8 began using a wheelchair, the OT [Occupational Therapist] stated, "...did not recommend a wheelchair... considered him ambulatory..." The DON stated, "...we can put them [indicating the residents] in a wheelchair can't we..." When asked for a plan to get Resident #8 back to baseline [ambulatory], there was no response from the fall team.

3. During an interview with the fall team on 7/14/11 at 10:55 AM to 12:00 PM, the DON stated the fall team included the DON, the MDS / care plan LPN, the Quality Assurance (QA) Registered Nurse (RN), the OT and the restorative CNA. The DON stated the fall team meets daily Monday through Friday in the morning meeting to discuss falls. The DON stated the nurses on the floor try to put an intervention in place immediately when a fall occurs. The fall team looks over the event report to determine if the proper intervention was implemented, to determine the root cause of the fall and try to address the cause with an intervention. The DON stated the proper intervention could be medical management. When asked to explain the intervention of medical management, the DON was unable to give a definite answer. The DON stated medical management could be antibiotics, fluids and cranberry juice for a urinary tract infection or it could be psychiatric medical management. The DON stated if a resident was sent to the emergency room after a fall, the intervention would be medical management.
The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:

Based on review of the "Falling Star Program" (policy/procedure for prevention of falls), review of Event Documentation forms, medical record review, observation and interview, it was determined the facility failed to implement care plan interventions for a resident at risk for falls for 1 of 20 (Residents #3) sampled residents identified with falls. Resident #3 was assessed as being at risk for falls. Resident #3 sustained eight falls from 2/3/11 to 7/4/11. Five falls resulted in serious injuries such as lacerations with sutures, one fall sustained a chipped tooth and the fall on 7/4/11 resulted in a fractured nose. The facility's failure to implement interventions to protect the resident after each of these falls placed Resident #3 in immediate jeopardy as evidenced by repeated falls with serious injuries that required medical interventions.

A conference was held with the Administrator, in the Administrator's office on 7/4/11 at 5:17 PM, to inform him of the surveyor's findings that placed Resident #3 in immediate jeopardy.

The findings included:

Review of the facility's "FALLING STAR PROGRAM", updated 4/5/10, documented, "All residents in the facility are at risk for falls.

A. Immediately after each fall, resident is assessed and treated for any injuries. Nurse will try to determine root cause, address individual needs, initiate Bowel and Bladder Assessment, complete Fall Risk Assessment and implement appropriate interventions per Standard Operating Procedure for Falls. Resident is also placed on Falling Star Program after initial fall.

- Res. #3 – 1:1 Nurse aide began immediately at 1:00pm on 07/14/11 for 30 days to observe B & B patterning, bed and w/c exit attempts and identify possible causes. Will re-evaluate after 30 days and plan accordingly.
- Order obtained from physician for P/T eval for seating device.
- Drop seat w/c provided by P/T.
Continued From page 42
however, we are going to pay closer attention to those that score a 20 and above on their fall risk assessment, as well as those who have fallen in the last 3 months. As a facility, we will... 5. Look in residents room to check for safety during rounds and as we pass by the room. It is the responsibility of nursing and housekeeping staff to ensure a safe environment..."

Medical record review for Resident #3 documented an admission date of 1/31/06 and diagnoses including Hepatitis C, Cirrhosis of Liver, Chronic Liver Disease, Arrhythmia, Esophageal Reflux, Diabetes Mellitus, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Generalized Anxiety Disorder, Delusions. The most recent quarterly Minimum Data Set (MDS) assessment for Resident #3 was completed 5/20/11. This assessment documented no problem with communication, she was understood by others and understood others. Resident #3’s cognitive status was evaluated with Brief Interview of Mental Status (BIMS), with a score of 5, indicating severe cognitive impairment. Review of Resident #3’s care plan documented a problem of “Risk for falls if related to impaired physical mobility, psychiatric medication use. Non-compliant with requesting assistance and safety interventions and non-compliant with alarms.” The goal of this care plan was “No fall related injuries.” The care plan was documented with target dates of 3/4/11 and 5/27/11.

a. Review of Resident #3’s nurse’s notes dated 2/13/11 documented, “At 0545 hrs, alarm was heard in Res [Resident] room CNA [Certified Nurse Assistant] went to get alarm & [and]
F 282  Continued From page 43
found Res face down on floor, blood under her head. CNA called this nurse to room ...LPN [Licensed Practical Nurse] also came to Res room. Pressure was applied to sight on (R) [Right] side of forehead. Gash approximated @ [at] 1 1/2 to 2 inches in length. Res had blood coming from (R) nostril. 911 was called..."
Nurse's notes further documented Resident #3 was returned to the facility the same day with sutures to the right forehead.

The Event Documentation form for the fall of 2/13/11 documented the resident was trying to stand from the wheelchair (w/c) at the time of the fall.

There was no evidence the care plan interventions for fall risks "...Dyco [non-slip material] to w/c...Except for bed and bathroom times keep resident in lobby or observation, ...Self release belt alarm in w/c..." were being implemented at the time of Resident #3's fall on 2/13/11.

b. Review of Resident #3's nurse's notes dated 3/11/11 at 2:00 AM documented, "Resident called for help. Upon entering room found resident lying beside bed (in lowest position) c [with] blankets in hand. No c/o's [complaints] verbalized... No injuries apparent."

The Event Documentation form for the fall of 3/11/11 documented no appliances/devices or interventions in place at the time of the fall.

There was no evidence the care plan interventions for fall risks "...Lowbed with mats on floor, FALLING STARS PROGRAM... Bed
**continued from page 44**

F 282 pressure alarm, Toilet plan, ...Dycem under floor alarm mat..." were being implemented at the time of Resident #3's fall on 3/11/11.

c. Review of Resident #3's nurse's notes dated 3/14/11 at 4:30 PM documented, "CNA heard resident moaning, walked into rm [room] found resident laying face down on floor on left side of bed. Resident [resident] cut (L) left forehead, glasses broke, large puddle of blood noted, Incision cleaned, sterile strips applied. Hospice nurse to come eval [evaluate]." Subsequent nurse's notes documented the hospice nurse visited; the resident was transferred to the Emergency Room via ambulance and returned to the facility after having a CT [Computerized Tomography] scan of the head and receiving 7 sutures to the left forehead. The nurse's notes dated 3/14/11 documented, "Large amount of edema at [and] discoloration noted to entire (L) orbital area."

The Event Documentation form for the fall of 3/14/11 documented no appliances/devices in place at the time of the fall and documented, "What was resident doing at time of fall? Not sure."

There was no evidence the care plan interventions for fall risks "...lowed with mats on floor, FALLING STAR PROGRAM, Keep wheelchair out of room, ...

...Except for bed and bathroom times keep resident in lobby for observation, ...Motion detector 'smart alarm' in bathroom on at all times. Bed pressure alarm, ...

...Hipsters as tolerated, Dycem to w/c, No bedside commode, Toilet plan, Under seat alarm, Dycem under floor alarm mat, Alarming w/c.

C. On 07/14/11 the CNA doing 1:1 was educated as to exactly why she was doing 1:1 with Resident #3 (to observe bed and w/c exit attempts, B&B patterning, and other possible causes).

3-11 and 11-7 shift staff was in-serviced by the Administrator on Falling Star Program and have the patients at risk pointed out to them on their assignment sheets. All 7-3 shift, weekend shifts, and personnel off duty were in-serviced upon their next working shift.

- We will audit Fall Risk Assessments to ensure they are done timely upon admission, quarterly, and after each fall.

- All staff will be in-serviced by D.O.N. or supervisor upon hire, annually, and as necessary with Falling Star Policy and Procedure.

- Fall Risk Committee will meet weekly in separate meeting to review incidents of falls and implement appropriate interventions/devices. Falls Risk Committee consists of
**NAME OF PROVIDER OR SUPPLIER**  
SPRING MEADOWS HEALTH CARE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**  
220 STATE ROUTE 76  
CLARKSVILLE, TN 37043

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| F 282 | Continued From page 45 | pressure mat” were being implemented at the time of Resident #3’s fall on 3/14/11.  
d. Review of Resident #3's nurse's notes dated 3/26/11 at 5:10 PM documented, "Called to room by CNA who states she heard alarm in room & [and] upon entering noted resident face down on floor beside bed. Bleeding from R eyebrow - ice applied." Subsequent nurse's notes documented the resident was sent to the ED [emergency department] and returned with "steri strips D & I [dry and intact] (L) forehead. Bruising noted around ou [both eyes], nose et [and] forehead."  
The Event Documentation form for the fall of 3/26/11 documented no appliances/devices or interventions in place at the time of the fall and documented the resident was "Trying to get OOB [out of bed]" at the time of the fall.  
There was no evidence the care plan interventions for fall risks "...Low bed with mats on floor, FALLING STAR PROGRAM, Keep wheelchair out of room, ...Except for bed and bathroom times keep resident in lobby for observation, ...Motion detector 'smart alarm' in bathroom on at all times, Bed pressure alarm, ...Hipsters as tolerated, ...No bedside commode, Toilet plan, ...Dycem under floor alarm mat, ...Grey floor pressure mat" were being implemented at the time of Resident #3’s fall on 3/26/11.  
e. Review of the nurse’s notes dated 6/10/11 at 1:20 AM documented, "This nurse was called to Room (#) where Res was laying on the floor face up, on her back... LPN was applying pressure to |

O/T, P/T, MDS, Restorative CNA and QA Nurse. Weekly this committee will address every fall and evaluate devices and the effectiveness of interventions. And meeting will documented in QA Fall Team Minutes. All falls will continue to be reviewed and addressed every morning at which time we will review incident documentation, devices used, effectiveness and appropriateness. We will check to see if resident has had previous falls and how many for the past 180 days. Nursing and CNA Care Plans will be updated to reflect changes in interventions. Nursing documentation X 3 days after fall will be reviewed for implementation, effectiveness, and appropriateness.
F 282: Continued From page 46
wound [upper] (R) [right] eye to stop the bleeding of the open area. The area & (R) side of Res face was purple in color, edematous [edematous]...911 was called...transferred via ambulance...
Nurse's notes documented the resident was sent to the emergency room (ER) and returned with sutures above the Right eye.

The Event Documentation form dated 6/10/11 documented types of injury included laceration, hematoma, skin tear and chipped front tooth and documented the resident was getting out of bed at the time of the fall.

There was no evidence in the care plan interventions for fall risks "...Lowed with mats on floor, FALLING STAR PROGRAM, Keep wheelchair out of room, ...Motion detector 'smart alarm' in bathroom on at all times, ...Hipsters as tolerated, Dycem to wc, No bedside commode, Toilet plan... Under seat alarm, Dycem under floor alarm mat, Alarming wc pressure mat, Pad sharp edges in room to prevent injury" were being implemented at the time of Resident #3's fall on 6/10/11.

f. Review of the nurse's notes dated 6/12/11 at 11:30 AM, documented, "CNA reports that she heard alarm & entered Rm (#) & noted resident on floor on (L) side in front of W/C & recliner. Denies pain or discomfort. No Injuries..."

The Event Documentation form dated 6/12/11 documented the resident was attempting to transfer from the wheelchair to the recliner without assistance at the time of the fall.

There was no evidence the care plan

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<tr>
<td>F 282</td>
<td>QA Nurse or designee will perform audits. Fall Risk Committee and Rehab Manager or designee will monitor to ensure audits are done weekly and as needed. Results will be reported to Administrator or D.O.N. designee. We will follow disciplinary process of verbal warning, written warning, suspension leading to possible termination. Charge Nurse, Nurse Supervisor, D.O.N. designee and Administrator will monitor Nursing's performance of implementing the intervention for the fall. The Human Resources Director will monitor through existing corporate compliance program and report any unresolved concerns.</td>
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<td>F 282</td>
<td>07/24-11</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**[X1] PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:**

- A. Building: ____________
- B. Wing: ____________

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<tr>
<td>F 282</td>
<td>Continued From page 47 interventions for fall risks &quot;...FALLING STAR PROGRAM...Except for bed and bathroom times keep resident in lobby for observation, ...Hipsters as tolerated, Dycem to w/c, ...Pad sharp edges in room, Floor mat alarm&quot; were being implemented at the time of Resident #3's fall on 6/12/11.</td>
<td>F 282</td>
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<td>g.</td>
<td>Review of the nurse's notes dated 6/14/11 at 12:00 PM documented, &quot;This nurse called to resident's room per CNA - upon entering room noted resident lying on floor beside roommate's bed - prone position - resident states, &quot;I got out w/c to go to BR [bathroom]&quot; - chair alarms were in place - upon assessment noted a moderate amt [amount] sanguineous [sanguineous] [bloody] drainage on floor - noted (3) lacerations forehead, noted open area bridge of nose - noted [upper] lip  și [slightly] swollen - resident do[complaint] HA [headache].&quot; Subsequent notes documented the resident was sent to the ER and returned with sutures to the left eyebrow, bridge of nose and left forehead. There was no evidence the care plan interventions for fall risks &quot;FALLING STAR PROGRAM... Except for bed and bathroom times keep resident in lobby for observation, ...Motion detector 'smart alarm' in bathroom on at all times, ...Dycem to w/c, No bedside commode, Toilet plan...&quot; were being implemented at the time of Resident #3's fall on 6/14/11.</td>
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<td>h.</td>
<td>Review of the nurse's notes dated 7/4/11 at 3:00 PM documented, &quot;This nurse called to resident's room per CNA - upon entering room noted resident lying on floor - face down- mod amt blood noted on floor- forehead states, 'I fell'</td>
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| F 282 | Continued From page 48 | ...to ER..." Subsequent nurse's notes revealed a CT of the head revealed a nasal fracture and the resident received sutures before returning to the facility. The Event Documentation form for this fall documented the resident was attempting to get out of the wheelchair without assistance at the time of the fall.

There was no evidence the care plan interventions for fall risks "...FALLING STAR PROGRAM, ...Except for bed and bathroom times keep resident in lobby for observation, ...Dycem to wc, No bedside commode, Toilet plan, ...Grey floor pressure mat, ...Floor mat alarm, ...Redirect to social area or back to DR during meals..." were being implemented at the time of Resident #3's fall on 7/4/11.

Observations in Resident #3's room on 7/11/11 at 11:18 AM, revealed Resident #3 in a low bed with dark brown eschar on her forehead, nose and chin and greenish-yellow discoloration to the right cheek. Resident #3 was receiving oxygen via binasal cannula at 2 liters a minute. Gray floor mats were observed on both sides of the very low bed, and falling star signs were on the foot of the bed and the door frame. A wc was parked at the foot of the bed with a seat sensor and portable oxygen tank attached. There was no motion sensor alarms observed in the room, there was no padding to sharp edges of doors or furniture observed in the room as care planned.

The interventions of keep wc out of room, motion detector smart alarms in the bathroom, and pad sharp edges in room were not implemented as
F 282  Continued From page 49  
care planned.  

During an interview with the fall team on 7/14/11 at 10:55 AM to 12:00 PM, the Director of Nurses (DON) stated the fall team included the DON, the minimum data set (MDS) care plan LPN, the Quality Assurance (QA) Registered Nurse (RN), the Occupational Therapist (OT) and the restorative CNA. The DON stated the fall team meets daily Monday through Friday in the morning meeting to discuss falls. She stated the nurses on the floor try to put an intervention in place immediately when a fall occurs. The fall team looks over the event report to determine if the proper intervention was implemented, to determine the root cause of the fall and try to address the cause with an intervention. The DON stated the proper intervention could be medical management. When asked what she would expect the nursing staff to implement for the intervention of medical management on a care plan, the DON stated it could be antibiotics, fluids and cranberry juice for a urinary tract infection or it could be psychiatric medical management. The DON stated if a resident was sent to the emergency room after a fall, the intervention would be medical management. The DON was asked what interventions were in place to prevent falls for Resident #3. The DON stated, 

"...not trying to prevent her falls, just trying to prevent her injuries." The DON stated, "She [Resident #3] knows how to beat the alarms, when she had pressure chair alarms before, she knew to put a book in the chair so the alarm would not sound when she stood... She had no falls from 11/28/09 until 2011. ...Short of restraining her [Resident #3], it is difficult to prevent falls, she has the right to fall... They [indicating the federal survey from...
Continued From page 50

Centers for Medicare and Medicaid Services [CMS] present in the meeting] say she has the right to fall... Out of a hundred or so residents, she [Resident #3] is an isolated case. Alarms work more effectively on some than on others, we move from one alarm to another and revisit them quarterly and/or with falls. We have a lot of new and innovative interventions. We feel [Resident #3] is a very unique case and is looked at over the years. She [Resident #3] went a year without a fall and I'm very pleased."

Resident #3 sustained eight falls from 2/13/11 to 7/4/11. Five falls resulted in lacerations that required sutures; she sustained a chipped tooth on 6/14/11 and a fractured nose on 7/4/11. The facility's failure to implement interventions to protect the resident after each of these falls placed Resident #3 in immediate jeopardy evidenced by serious injuries that required medical interventions.

Observations in Resident #3's room on 7/15/11 at 8:30 AM revealed Resident #3 was up in her w/c at bedside, with a reverse torso support in place, being fed breakfast by CNA #5. At 9:30 AM, Resident #3 was observed in bed in her room, CNA #5 was seated at bedside.

During an interview in Resident #3's room on 7/15/11 at 9:35 AM, CNA #5 stated her assignment for that shift was to provide 1:1 care for Resident #3, document her toileting concerns each hour, and document any attempts to exit the bed or the w/c. CNA #5 stated she was told someone will be assigned to the resident for 30 days.
Continued From page 51
During an interview on 7/15/11 at 9:40 AM at the #1 Nursing Station, Nurse #5 stated, "1:1 supervision will be continued 30 days and re-evaluated until we know she is safe at the highest level of functioning.

The Immediate Jeopardy was lifted on 7/15/11 at 5:05 PM and noncompliance still continues at a lower scope and severity level of D. Refer to F323.

F 309 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 closed medical record review and interview, it was determined the facility failed to follow physician's orders to elevate the resident's feet at least four hours each day for 1 of 31 (Resident #23) sampled residents.

The findings included:
Closed medical record review for Resident #23 documented an admission date of 5/11/10 with diagnoses of Alzheimer's Disease, Atrial Fibrillation, Hypertension, history of Prostate Cancer and Cerebrovascular Accident. Review of a physician's order stamped 7/15/2010 and signed by the nurse as reviewed on 6/27/10 documented, "...TREATMENTS...ELEVATE
F 309 Continued From page 52

FEET AT LEAST 4 HOURS PER DAY... TED HOSE [antiembolitic stockings] USE AS DIRECTED." There was an undated order in the medical record from a (named hospital) signed by a physician to "Please Elevate Feet at least 4 hr [hour]/[per] day." Review of the facility treatment record for Resident #23 documented "ELEVATE FEET AT LEAST 4 HOURS PER DAY." There was no documentation on the treatment record that the Resident #23's feet had been elevated during the month of July 2011. Review of the Nurse Aide (NA) care plan record and form documenting the Certified Nursing Assistant (CNA) assumed "accountability for following the care plan" revealed no documentation that Resident #23's feet were to be elevated.

During an interview at Nurse Station 1 on 7/14/11 at 11:20 AM, CNA #2 stated how she would know to elevate a resident's feet if ordered by the physician. CNA #2 stated, "it should be on the CNA care plan and then checked off on the sheet [form documenting the CNA assumes accountability for following the care plan]. Will talk to medical records..." There was no other documentation provided to the surveyor that the physician's order was followed.

During an interview in the Director of Nursing's (DON) office on 7/15/11 beginning at 8:30 AM, with the DON and Nurse #12 present, the surveyor asked about the physician's order for elevating Resident #23's feet. The DON stated, the physician "order from [named hospital] looks like it was 6/18... See where they have TED stockings on." Nurse #12 identified the order to elevate the feet 4 hours per day "documented on the TAR [Treatment Administration Record] but never signed off." The DON stated, "if documented on the TAR expect that the nurse..."

C. Staff in-serviced that all orders should be time specific, and FYI is not to be used. All orders that were not time specific have been changed. All orders to elevate feet will be put on every care plan. All orders to elevate feet will also be put on the treatment record and documented with specific time or shift on the TAR. The charge nurse and/or supervisors will do daily rounds to ensure ordered interventions are being followed. Any staff found to be deficient in the practice will be counseled by the end of the shift.

D. The treatment nurse or designee will audit treatment records and care plans weekly to ensure all ordered treatment interventions are being followed and documented.
F 309 Continued From page 53

would assure CNA do the treatment." The DON requested that Nurse #5 be in the interview as she had provided care for Resident #23. Nurse #5 had reviewed the medical record and stated elevating the feet was only an "FYI [for your information]." Nurse #5 was asked if she would expect that nurses document an FYI treatment. Nurse #5 stated, "Oh my goodness, the FYIs ...not something we document." Nurse #5 was asked how a specific physician order is changed from an order to an FYI. Nurse #5 stated, "We absolutely follow orders." Nurse #5 did not answer the question of how the order gets changed to an FYI. Nurse #5 was asked where the FYI would be documented. Nurse #5 stated, "In the nurses notes as it is a standard of practice and facility protocol to elevate the feet if the resident has TED stockings on. The DON also stated that it was facility policy and standard of practice to elevate the feet on any resident wearing TED stockings. The facility was unable to provide a policy or standard of practice for elevating the feet of a resident if they were ordered to wear TED stockings. Nurse #5 was asked if the physician writing the order for the elevation of the feet was aware of the facility protocol or standard of practice. Nurse #5 stated, "He didn't write that ...that's a form" but acknowledged that it was the physician's signature stamped 7/15/2010 and dated 6/27/2010 by the nurse reviewing the order and that the form included medications that the resident was to receive. At 10:30 AM, the DON was asked if she would expect nurses to follow physician orders and document them. The DON stated, "Would expect that nurses follow physician orders" but was unable to identify the documentation that the physician's order to
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<td>F 309</td>
<td>Continued From page 54 elevate the feet at least four hours a day had been followed.</td>
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<td>F 323</td>
<td>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</td>
<td>F 323</td>
<td>7/14/11 A. Immediately after each fall resident is assessed and treated for any injuries. Nurse will try to determine root cause, address individual needs, initiate Bowel and Bladder Assessment, complete Fall Risk Assessment and implement appropriate interventions per Standard Operating Procedure for Falls. Resident is also placed on Falling Star Program after initial fall. Res. # 3 – 1:1 Nurse aide began immediately at 1:00pm on 07/14/11 for 30 days to observe B &amp; B patterning, bed and w/c exit attempts and identify possible causes. Will re-evaluate after 30 days and plan accordingly.</td>
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<td>The facility must ensure that the resident environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents.</td>
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This REQUIREMENT is not met as evidenced by:

Based on policy review, review of the "Falling Star Program", review of "Event Documentation" forms, medical record review, observation and interview, it was determined the facility failed to ensure residents at risk for falls were adequately supervised and had interventions implemented after each fall for 2 of 20 (Residents #3 and 8) sampled residents identified with falls. Resident #3 was assessed as being at risk for falls. Resident #3 sustained eight falls from 2/3/11 to 7/4/11. Five falls resulted in serious injuries such as lacerations with sutures, one fall sustained a chipped tooth and the fall on 7/4/11 resulted in a fractured nose. The facility’s failure to provide adequate supervision to prevent injuries from falls, and to develop and implement interventions to protect the resident after each of these falls placed Resident #3 in immediate jeopardy as evidenced by repeated falls with serious injuries that required medical interventions, and resulted in substandard quality of care.
**SPRING MEADOWS HEALTH CARE CENTER**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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**DATE SURVEY COMPLETED**

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**NAME OF PROVIDER OR SUPPLIER**

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<td>220 STATE ROUTE 76</td>
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<tr>
<td>CLARKSVILLE, TN 37043</td>
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| F 323 | Continued From page 55 |

A conference was held with the Administrator, in the Administrator's office on 7/14/11 at 5:17 PM, to inform him of the surveyor's findings that placed Resident #3 in immediate jeopardy.

The findings included:

1. Review of the facility's "Standard Of Procedure For Falls" policy documented, "1. After assessment & [and] treatment of any injuries, Resident to be checked to identify where fall originated/root cause. 2. Staff to address individual need. (ex: [example such as] toileting, bed, hunger, thirst, etc. [et cetera]) 3. If applicable, initiate Bowel and Bladder assessment x [times] 3 days 4. Complete Fall Risk Assessment..."

2. Review of the facility's "FALLING STAR PROGRAM", updated 4/5/10, documented, "All residents in the facility are at risk for falls, however, we are going to pay closer attention to those that score a 20 and above on their fall risk assessment, as well as those who have fallen in the last 3 months. As a facility, we will... 5. Look in residents room to check for safety during rounds and as we pass by the room. It is the responsibility of nursing and housekeeping staff to ensure a safe environment. 6. Check the resident fall-prevention alarms for proper placement and function each shift and as needed. It is the charge nurses responsibility to audit resident safety devices each shift..."

3. Medical record review for Resident #3 documented an admission date of 1/31/06 and diagnoses including Hepatitis C, Cirrhosis of Liver, Chronic Liver Disease, Atrial Fibrillation,  

**ID PREFIX TAG**

| F 323 |

- Order obtained from physician for P/T eval for seating device.
- Drop seat w/c provided by P/T.
- Reverse Torso Support while up in chair.
- Installed Smart Alarm Sensor
- New fall risk assessment done and Care Plan updated.
- All patients at risk for falls will be re-assessed by P/T to ensure devices in use are effective and appropriate on 07/14/11.

Resident #8 had fall risk assessment done on 07/14/11 and had 1:1 supervision X 24 hrs, with no w/c or bed exit attempts identified. P/T screened on 07/14/11 to ensure proper devices were in place and recommended ambulation 2 X per day with rolling walker and 2 person assist.
**F 323**

Continued From page 56

Esophageal Reflux, Diabetes Mellitus, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Generalized Anxiety and Delusions. The most recent minimum Data Set (MDS) assessment for Resident #3 was completed 5/20/11. This assessment documented no problem with communication, she was understood by others and understood others. Resident #3’s cognitive status was evaluated with brief interview of mental status (BIMS), with a score of 6, indicating severe cognitive impairment. Resident #3’s care plan was documented with target dates of 3/4/11 and 5/27/11. The care plan documented problem of “Risk for falls rt [related to] impaired physical mobility, psych [psychiatric] med [medication] use. Non-compliant with requesting assistance and safety interventions and non-compliant with alarms.” The goal for this problem was documented as “No fall related injuries.”

a. Review of Resident #3’s nurse’s notes dated 2/13/11 documented, “At 0545 hrs [hours] alarm was heard in Res [Resident] room CNA [Certified Nurse Assistant]….went to get alarm & found Res face down on floor, blood under her head. CNA called this nurse to room….LPN [Licensed Practical Nurse] also came to Res room. Pressure was applied to site on (R) [Right] side of forehead. Gash approximated @ [at] 1 1/2 to 2 inches in length. Res had blood coming from (R) nostril. 911 was called….” Nurse’s notes further documented the resident was returned to the facility the same day with sutures to the right forehead.

The Event Documentation form dated 2/13/11 documented the resident fell while trying to stand

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**B.**

New fall risk assessments were done on all patients on 07/14/11.

- Audit of fall risk assessment to identify that assessments are completed upon admission, quarterly, and after each fall.
- Identify patients who are Falling Stars on each shift’s CNA assignment sheet to increase their awareness of those identified at risk.
- P/T screening after each fall within 72 hours.
- Re-enforce Falling Star Program through inservice.
- Follow Standard Operating Procedure for Falls.
- Within one week the team will network with our resources within the association and our sister facility to get ideas on successful strategies for preventing and dealing with resident falls.
**C.** On 07/14/11 the CNA doing 1:1 was educated as to exactly why she was doing 1:1 with Resident #3 (to observe bed and w/c exit attempts, B&B patterning, and other possible causes).

3-11 and 11-7 shift staff was in-serviced by the Administrator on Falling Star Program and have the patients at risk pointed out to them on their assignment sheets. All 7-3 shift, weekend shifts, and personnel off duty were in-serviced upon their next working shift.

- We will audit Fall Risk Assessments to ensure they are done timely upon admission, quarterly, and after each fall.
- All staff will be in-serviced by D.O.N. or supervisor upon hire, annually, and as necessary with Falling Star Policy and Procedure.
- Fall Risk Committee will meet weekly in separate meeting to review incidents of falls and implement appropriate interventions/devices. Falls
**Summary Statement of Deficiencies**

- **F 323** Continued From page 58 pressure alarm, Toilet plan, ...Dycem under floor alarm mat..." were being implemented at the time of Resident #3's fall on 3/14/11.
  
  c. Review of Resident #3's nurse's notes dated 3/14/11 at 4:30 PM documented, "CNA heard resident moaning, walked into rm [room] found resident laying face down on the floor on left side of bed. Resident [resident] cut [L] [left] forehead, glasses broke, large puddle of blood noted. Incision cleaned, suture strips applied. Hospice nurse to come eval [evaluate]." Subsequent nurse's notes documented the hospice nurse visited; the resident was transferred to the Emergency Room [ER] via ambulance and returned to the facility after having a CT [Computerized Tomography] scan of the head and receiving 7 sutures to the left forehead. The nurse's notes dated 3/14/11 documented, "Large amount of edema at [and] discoloration noted to entire (L) orbital area."

The Event Documentation form for the fall of 3/14/11 documented no appliances/devices in place at the time of the fall and documented, "What was resident doing at time of fall? Not sure." This form documented, "Actions / Interventions ...Add floor pressure mat to prevent injury."

Review of Resident #3's care plan for risk for falls revealed the intervention, "3-14-11 Add Grey floor pressure mat" was handwritten on the care plan. The intervention "Floor pressure sensitive alarm" was documented on the current care plan for risk for falls. This intervention had a single line marked through it and "D/C [discontinue]" written beside the intervention. There was no date to

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**Risk Committee consists of O/T, P/T, MDS, Restorative CNA and QA Nurse. Weekly this committee will address every fall and evaluate devices and the effectiveness of interventions. And meeting will documented in QA Fall Team Minutes. All falls will continue to be reviewed and addressed every morning at which time we will review incident documentation, devices used, effectiveness and appropriateness. We will check to see if resident has had previous falls and how many for the past 180 days. Nursing and CNA Care Plans will be updated to reflect changes in interventions. Nursing documentation X 3 days after fall will be reviewed for implementation, effectiveness, and appropriateness.**
F 323 Continued From page 59

There was no evidence the care plan interventions for fall risks "...Low bed with mats on floor, FALLING STAR PROGRAM, Keep wheelchair out of room, ...Except for bed and bathroom times keep resident in lobby for observation, ...Motion detector 'smart alarm' in bathroom on at all times, Bed pressure alarm, ...Hipsters as tolerated, Dymo on w/c, No bedside commode, Toilet plan... Under seat alarm, Dymo under floor alarm mat, Alerming w/c pressure mat" were being implemented at the time of Resident #3's fall on 3/14/11.

d. Review of Resident #3's nurse's notes dated 3/25/11 at 5:10 PM documented, "Called to room by CNA who states she heard alarm in rm & upon entering noted resident face down on floor beside bed. Bleeding from R eyebrow - ice applied." Subsequent nurse's notes documented the resident was sent to the ED [emergency department] and returned with "steri strips D & I [dry and intact] (L) forehead. Bruising noted around or [both eyes], nose et [and] forehead."

The Event Documentation form for the fall of 3/14/11 documented no appliances/devices in place at the time of the fall and documented the resident was trying to get out of bed at the time of the fall.

There was no evidence the care plan interventions for fall risks "...Low bed with mats on floor, FALLING STAR PROGRAM, Keep wheelchair out of room, ...Except for bed and bathroom times keep resident in lobby for..."
Continued From page 50

observation, ...Hipsers as tolerated, No bedside commode, Toilet plan, Dyceem under floor alarm mat, Grey floor pressure mat" were being implemented at the time of Resident #3's fall on 3/26/11.

e. Review of the nurse's notes dated 6/10/11 at 1:30 AM documented, "This nurse was called to Room # where Res [Resident] was laying on the floor face up, on her back... LPN was applying pressure to wound [upper] (R) eye to stop the bleeding of the open area. The area & (R) side of Res face was purple in color, edematous... 911 was called... transferred via ambulance..." Nurse's notes documented the resident was sent to the Emergency Room and returned with sutures above the Right eye.

The Event Documentation form for the fall of 6/10/11 documented the resident was getting out of bed at the time of the fall, documented types of injury included laceration, hematology, skin tear and chipped front tooth, and documented "Actions/Interventions: Reorientate Res on call light use. Remind Res of time of night of [due to] loss [possible] time confusion. Pharmacy review. Add floor pressure mat alarm - app. [approved] per fall team."

Review of Resident #3's care plan for risk for falls revealed the intervention floor pressure sensitive alarm that had been marked through, and the intervention of "Grey floor pressure mat" added 3/14/11. There was no new fall intervention was developed or implemented after this fall.

There was no evidence the care plan interventions for fall risks "...Lowed with mats on..."
Continued From page 61

F 323 Localized From page 61

FLOOR, FALLING STAR PROGRAM, Keep
wheelchair out of room, ...Motion detector 'smart
alarm' in bathroom on at all times, ...Hipsters as
intolerated, Dycem to w/c, No bedside commode,
Toilet plan... Under seat alarm, Dycem under
floor alarm mat, Alarming w/c pressure mat, Pad
sharp edges in room to prevent injury' were being
implemented at the time of Resident #3's fall on
6/10/11.

i. Review of the nurse's notes dated 6/12/11 at
11:30 AM, documented, "CNA reports that she
heard alarm & entered Rm (#) & noted resident
on floor on (L) side in front of WC & recliner.
Denies pain or discomfort. No injuries..."

The Event Documentation form for this fall
documented the resident was trying to transfer
from the wheelchair to the recliner at the time of
the fall, and "Actions/Interventions: (Medical
management - UA [urinalysis] C&S [culture and
sensitivity]) per fall team."

Review of the resident's laboratory results
revealed a urine specimen, collected 6/14/11,
urinalysis was negative, and urine culture
revealed no growth. The laboratory results
documented the physician was notified 6/15/11.
There was no documentation the laboratory
results had been reviewed by the fall team, or any
additional interventions had been attempted after
the laboratory results were received.

There was no evidence the care plan
interventions for fall risks "...FALLING STAR
PROGRAM, ...Except for bed and bathroom
times keep resident in lobby for observation,
...Hipsters as tolerated, Dycem to w/c, Dycem
F 323 Continued From page 62
under floor alarm mat, ...Grey floor pressure mat, Pad sharp edges in room" were being implemented at the time of Resident #3's fall on 6/12/11.

g. Review of the nurse's notes dated 6/14/11 at 12:00 PM documented, "This nurse called to resident's room per CNA - upon entering room noted resident lying on floor beside roommate's bed - prone position - resident states, "I got out w/c to go to BR [bathroom]" - chair alarms were in place upon assessment noted a moderate amt [amount] sanguineous [sanguineous] [bloody] drainage on floor - noted (3) lacerations forehead, noted open area bridge of nose - noted [upper] lip sl [slightly] swollen - resident c/o [complaint] HA [headache]." Subsequent notes documented the resident was sent to the ER and returned with sutures to the left eyebrow, bridge of nose and left forehead.

The Event Documentation form for this fall documented the resident was getting out of the wheelchair without assistance at the time of the fall. The event documentation dated 6/14/11 documented "Actions/Interventions" implemented as "Make sure resident does not go to room p [after] leaving DR - keep DR [dining room] or TV [television] area until staff finished c [with] meals. Redirect to Social Area or DR at meals - per fall team."

Review of Resident #3's care plan for risk for falls revealed a handwritten intervention added, "6/14/11, Fall; Redirect to social area or back to DR during meals." A prior intervention of "Except for bed and bathroom times keep resident in lobby for observation." There was no new
Continued From page 63:

There was no evidence the care plan interventions for fall risks "Keep wheelchair out of room, ...Except for bed and bathroom times keep resident in lobby for observation, ...Motion detector 'alarm alarm' in bathroom on at all times, ...Dycem to w/c, No bedside commode, Toilet plan... Under seat alarm, Dycem under floor alarm mat. Alarming w/c pressure mat were being implemented at the time of Resident #3's fall on 6/14/11.

h. Review of the nurse's notes dated 7/4/11 at 3:00 PM documented, "This nurse called to resident's room per CNA - upon entering room noted resident lying on floor - face down- mod amount blood noted on floor - forehead states, 'I fell' ...to ER..." Subsequent nurse's notes revealed a CT of the head revealed a nasal fracture and the resident received sutures before returning to the facility.

The Event Documentation form for this fall documented the resident was attempting to get out of the wheelchair without assistance at the time of the fall. The form documented "head injury" and the Actions/Interventions for this fall were, "Resident sent to ED [Emergency Department] ...Medical Management per fall team."

Nurse's notes documented the resident returned to the facility 7/4/11 at 9:00 PM. There were no new interventions developed or implemented to prevent injuries from fall after this fall.
**F 323** Continued From page 54

There was no evidence the care plan interventions for fall risks "...FALLING STAR PROGRAM, Keep wheelchair out of room, ...Except for bed and bathroom times keep resident in lobby for observation, ...Motion detector’s smart alarm in bathroom on at all times, ...Dysm at w/c, No bedside commode, Toilet plan... Under seat alarm, ...Alarming w/c pressure mat, Grey floor pressure mat, ...Floor mat alarm, ...Redirect to social area or back to DR during meals..." were being implemented at the time of Resident #3’s fall on 7/4/11.

Fall risk assessments for Resident #3 were completed on 2/11/11, 3/3/11 and 5/25/11. Resident #3’s total score for each assessment was 18. The "Fall Risk Assessment" form documented, "Total score of 10 or above represents HIGH RISK." There was no documentation a fall risk assessment was completed after the falls on 2/13/11, 3/10/11, 3/14/11, 3/25/11, 6/10/11, 6/12/11, 6/14/11 and 7/4/11.

Observations in Resident #3’s room on 7/11/11 at 11:18 AM, revealed Resident #3 in a low bed with dark brown eschar on her forehead, nose and chin and greenish-yellow discoloration to the right cheek. Resident #3 was receiving oxygen via binaural cannula at 2 liters a minute. Floor mats were observed on both sides of the low bed, and falling star signs were on the foot of the bed and the door frame. A w/c was parked at the foot of the bed with a seat sensor and portable oxygen tank attached.

Observations in the TV area at Nursing Station 1 on 7/11/11 from 4:55 PM until 5:10 PM, revealed...
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CPSA IDENTIFICATION NUMBER: 445402

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ____________________
B. WING ____________________

(X3) DATE SURVEY COMPLETED 07/16/2011

NAME OF PROVIDER OR SUPPLIER SPRING MEADOWS HEALTH CARE CENTER
STREET ADDRESS, CITY, STATE, ZIP CODE 220 STATE ROUTE 76 CLARKSVILLE, TN 37043

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 323 Continued From page 65
Resident #3 seated in a high back wheelchair, sitting erect, with her feet barely touching the floor, while the staff changed the portable oxygen tank on the back of the w/c. The resident sat erect, then would lean back and then erect again, to the edge of the seat. There was no motion sensor alarms observed in the room, there was no padding to sharp edges of doors or furniture observed in the room as care planned.

The interventions of keep w/c out of room, motion detector smart alarms in the bathroom, and pad sharp edges in room were not implemented as care planned.

Observations on 7/12/11 at 7:48 AM, revealed Resident #3 in a high back wheelchair, being wheeled to the TV area by a staff member. When the staff member stopped pushing, Resident #3 immediately began propelling her w/c toward the dining room. An LPN at the nurse's station asked Resident #3 if she was going to the dining room. The LPN told Resident #3 she would come help her with her breakfast in a few minutes.

Observations in the dining room on 7/12/11 at 8:00 AM, revealed Resident #3 seated alone at a table in a high backed w/c.

During an interview with the fall team on 7/14/11 at 10:55 AM to 12:00 PM, the Director of Nurses (DON) was asked what interventions were in place to prevent falls for Resident #3. The DON stated, "...not trying to prevent her falls, just trying to prevent her injuries." The DON stated, "She [Resident #3] knows how to beat the alarms, when she had pressure chair alarms before, she knew to put a book in the chair so the alarm

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 323
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION)</th>
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</thead>
</table>
| F 323 | Continued From page 66 | | would not sound when she stood... She had no falls from 11/28/09 until 2011... Short of restraining her [Resident #3], it is difficult to prevent falls, she has the right to fall... They [indicating the federal surveyor from Centers for Medicare and Medicaid Services [CMS] present in the meeting] say she has the right to fall... Out of a hundred or so residents, she [Resident #3] is an isolated case. Alarms work more effectively on some than on others, we move from one alarm to another and revisit them quarterly and/or with falls. We have a lot of new and innovative interventions. We feel [Resident #3] is a very unique case and is looked at over the years. She [Resident #3] went a year without a fall and I’m very pleased."

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<tr>
<th>ID</th>
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<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
</table>
| F 323 | | | Resident #3 sustained eight falls from 2/13/11 to 7/4/11. Five falls resulted in lacerations that required sutures; she sustained a chipped tooth on 9/14/11 and a fractured nose on 7/4/11. The facility's failure to develop and implement interventions to protect the resident after each of these falls placed Resident #3 in immediate jeopardy as evidenced by serious injuries that required medical interventions.

Observations in Resident #3's room on 7/15/11 at 8:30 AM, revealed Resident #3 was up in her w/c at bedside, being fed breakfast by CNA #5 and was noted to have a reverse torso support in place. At 9:30 AM, Resident #3 was observed in bed in her room, CNA #5 was seated at the bedside.

An Allegation of Compliance (AOC) was received from the facility on 7/14/11 at approximately 8:00 PM with additional information received and
During an interview in Resident #3's room on 7/15/11 at 9:35 AM, CNA #5 stated her assignment for that shift was to provide 1 on 1 care for Resident #3, document Resident #3's toileting concerns each hour, and document any attempts to exit the bed or the w/c. CNA #5 stated she was told someone will be assigned to the resident for 30 days.

During an interview at the #1 Nursing Station, on 7/15/11 at 9:40 AM, Nurse #6 stated, "1:1 supervision will be continued 30 days and re-evaluated until we know she is safe at the highest level of functioning."

The Immediate Jeopardy was lifted on 7/15/11 at 5:05 PM and noncompliance still continues at the lower scope and severity level of D.

2. Medical record review for Resident #8 documented an admission date of 4/1/11 and a re-admission date of 7/1/11 with diagnoses of Diabetes Mellitus, Hyperlipidemia, Senile Delusions, Dementia with Behavior, Anxiety, Alzheimer's, Hypertension, Seizures and Depression. Review of the nurse's notes dated 4/2/11 at 1:00 PM documented, "...Resident up OOB [out of bed] for meal. Ambulate per self and ad lib [at liberty] ...5/20/11 11 AM ...Resident [symbol for up] ambulating in hallway ...6/4/11 4:15 PM ...Resident has unsteady on his feet." Review of the nurse's notes dated 6/18/11 at 4 PM documented, "Resident stood up from W/C and fell backwards over back of the chair, hit his head and shoulders first. Resident was unconscious X [times] 30 sec [seconds] to 1 min.
**F 323** Continued From page 88

[minute] Remained semi-conscious X 20 min...

Send to ER for evaluation and treatment..."

Review of the "Progress Note - Psychiatric...

...Date: 7/14/11... F/u [follow-up] readmission to facility 7/111 s/p [status post] intercranial hemorrhage [hemorrhage]...

Review of the care plan dated 5/19/11 documented, "...Risk for fall...

...6-18-11 Fall; Medical Management..." The facility failed to be specific with interventions put in place to prevent falls or injuries from falls.

Observations in the Old Wing TV room on 7/12/11 at 7:40 AM, revealed Resident #8 seated in wheelchair.

Observations in the TV room on the New Wing on 7/14/11 at 7:00 PM, revealed Resident #8 seated in a wheelchair with ear buds on. Smiling and appears to be moving with the music from the I-Pod.

During an interview with the fall team on 7/14/11 at 10:55 AM to 12:00 PM, when asked when did Resident #8 began using a wheelchair, the Occupational Therapist (OT) stated, ". . . did not recommend a wheelchair... considered him ambulatory..." The DON stated, ". . . we can put them [indicating the residents in a wheelchair can't we..." When asked for a plan to get Resident #8 back to baseline [ambulatory], there was no response from the fall team.

3. During an interview with the fall team on 7/14/11 at 10:55 AM to 12:00 PM, the DON stated the fall team included the DON, the minimum data set (MDS) / care plan LPN, the Quality Assurance (QA) Registered Nurse (RN), the OT and the restorative CNA. The DON stated the fall team meets daily Monday through Friday.
Continued from page 69

in the morning meeting to discuss falls. She stated the nurses on the floor try to put an intervention in place immediately when a fall occurs. The fall team talks over the event report to determine if the proper intervention was implemented, to determine the root cause of the fall and try to address the cause with an intervention. The DON stated the proper intervention could be medical management. When asked what she would expect the nursing staff to implement for the intervention of medical management on a care plan, the DON stated it could be antibiotics, fluids and cranberry juice for a urinary tract infection or it could be psychiatric medical management. The DON stated if a resident was sent to the emergency room after a fall, the intervention would be medical management.

F 332 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE

The facility must ensure that it is free of medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation and interview, it was determined the facility failed to ensure 3 of 8 (Nurses #6, 6 and 7) nurses administered medications with a medication error rate of less than 5 percent (%). A total of 3 errors were observed out of 42 opportunities, resulting in an error rate of 7.14%.

The findings included:

F 323 7/19/11 F332

A. Patient #21 MD was immediately informed. Orders received to hold iron and obtain STAT iron level. Results of iron level were within normal limits. Resident #21 vitals were obtained every 15 minutes x 2, then every 30 minutes x 2, then every 4 hours x 4, then every 8 hours x 3, then every 12 hours x 2 and she was monitored for signs and symptoms of adverse side effects, such as headache, diarrhea, stomach upset, cough and complaints of constipation. Resident did not exhibit any of these symptoms. On 07/18/11 ferrous sulfate was ordered for 15mg/0.6ml per tube bid. 3 cc of the OTC liquid iron constituted differently than 3 cc of ferrous sulfate liquid 15/mg/0.6ml. On 07/18/11 the ferrous sulfate was restarted and the correct type of liquid iron was delivered by pharmacy.
Continued From page 70

1. Medical record review for Resident #21 documented an admission date of 8/5/05 and readmission date of 3/18/10 with diagnoses including Dysphagia, Ulcer of Heel and Midfoot, Presbyopia, Neuropathy and Diabetes. Review of the physician's order dated 10/8/10 documented, "Ferrous Sulfate liquid (15mg [milligrams] / [per] 0.6 ml [milliliter]) Give 3 ml via Peg [percutaneous endoscopy gastrostomy tube] QD [everyday]..."
Three (3) ml of 15 mg/0.6 ml provides 75 mg Ferrous Sulfate.

Observations in Resident #21's room on 7/12/11 at 11:00 AM, Nurse #6 administered 3 ml of Ferrous Sulfate 220 mg/5 ml. Three ml of 220 mg/5 ml provides 132 mg Ferrous Sulfate, which resulted in medication error #1.

2. Medical record review for Random Resident (RR) #1 documented an admission date of 8/5/10 with diagnoses of Malignant Hypertension, Female Stress Incontinence, Hyperlipidemia, Friedreich's Ataxia and Senile Dementia. Review of the physician's orders dated 8/13/11 documented "Gabapentin 100 mg capsule, Take 1 capsule by mouth 3 times daily, 9 AM, 3 PM, 9 PM."

Observations in RR #1's room on 7/12/11 at 4:08 PM, Nurse #6 administered Gabapentin 100 mg.

During an interview at the New Wing nurse's station on 7/12/11 at 3:08 PM, Nurse #6 stated, "You have one hour before and one hour after to give a medicine." Nurse #6 verified she gave the Gabapentin more than one hour after it was ordered, which resulted in medication error #2.

B. All patients with orders for liquid iron have the potential to be affected by this deficient practice. 100% audit was done and no other patients had an order for liquid iron. The nurse who made the error has been counseled and was required to watch "The 5 Rights of Medication Administration".
C. All nursing staff were in
served on 07/22/11 and
07/23/11 to order all liquid
iron for any patient directly
from the Pharmacy and all
OTC liquid iron has
removed from the med
room and will no longer be
used. All nursing staff were
in-serviced to follow the 5
rights of medicine
administration, and to
compare dosages. In-
services will also be done
upon hire and annually by
nursing department.
Pharmacy consultant will
also perform monthly med
pass audits. Any nurse
found to deficient in the
practice will be counseled
by the D.O.N./designee and
will be required to watch
the “5 Rights of Med
Administration”. Any
nurse with frequent med
pass errors will be subject
to suspension and/or
termination.

D. Pharmacy consult will
perform monthly checks on all
patients who have liquid iron
ordered for correct dosages.
QA/designee will audit all
liquid iron orders to ensure
proper dosage is
administered, and that all
liquid iron is individually
ordered and delivered by the
Pharmacy. Supervisors will
do random med pass audits
weekly to ensure compliance.
Results of all audits will be
reported at QA Committee at
least quarterly.
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<tr>
<th>ID PREFIX TAG</th>
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| F 332        | Continued From page 71  
3. Medical record review for Resident #28 documented an admission date of 5/23/11 with diagnoses including Amputation Below the Knee, Altered Mental Status, Peripheral Vascular Disease, End Stage Renal Disease, Diabetes and Hypertension. The physician's order dated 7/9/11 documented decrease Renagel to 1 tablet by mouth (PO) three times a day (TID). Observations in Resident #28's room on 7/12/11 at 4:00 PM, Nurse #7 administered Renagel 4 tablets, resulting in medication error #3. 483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME  
Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.  
This REQUIREMENT is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to offer hour of sleep  |
| F 368        | 483.35(f) FREQUENCY OF MEALS/ SNACKS AT BEDTIME  
Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.  
This REQUIREMENT is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to offer hour of sleep  |

**F368** - HS Snack

A. CNA Care Plans were updated 7/13/11 to offer HS snacks nightly. The dietary department, Certified Nursing Assistants, Charge Nurses, and Nurse Supervisors were instructed effective immediately.

B. The facility will offer HS snack daily to all residents with exception to those with tube feeding and dietary restrictions. Documentation of acceptance and percentage consumed will also be done.
F 368  Continued From page 72

(5) snacks for 58 of 80 residents, on 4 of 4 (east, south, north and new wing halls) halls observed during the HS snack tour.

The findings included:

Observations of the delivery of HS snacks on east, south, north and new wing halls on 7/12/11 starting at 8:00 PM, revealed 58 of 80 residents observed were not offered a HS snack.

During an interview in Resident #15's room (south hall) on 7/12/11 at 8:48 PM, Resident #15 stated, "They [staff] don't offer snacks. We have to ask for them [snacks]..."

During an interview in Resident #10’s room (south hall) on 7/12/11 at 8:47 PM, Resident #10 was asked if they were offered HS snacks. Resident #10 stated, "No."

During an interview on the south hall on 7/12/11 at 9:05 PM, Certified Nursing Assistant (CNA) #3 stated he offered snacks to 6 of 16 residents on his (south) hall.

F 371  Continued From page 73

SS-F FOOD PROCURE,
STORE/PREPARE/SERVE - SANITARY

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

C. Staff was in serviced on 7/22/11 and 7/23/11 on offering HS snacks. A snack sheet has been implemented to insure all residents will be offered breakfast and record the percentage eaten. A HS snack cart has been implemented to offer different types of snacks and hydration choices. CNA care plans have been updated to offer residents HS snacks.

D. The HS snack audit sheet is to be signed by the CNA when snacks are offered. The Ward Clerk will audit the sheet each night. The Nursing supervisor or Charge Nurse will directly observe each week to ensure snacks are offered. QA nurse/designee will do a random audit each month. The QA nurse will report the results of the audits to the Medical Director in the QA committee meeting quarterly.

7/25/11  F371

A. The mixer and the stove were thoroughly cleaned on 07/11/11. All staff and vendors were informed to use hairnets before entering the kitchen on 07/11/11.
<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X5) COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 371</td>
<td>Continued From page 73</td>
<td>07/11/11</td>
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<tr>
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<td>This REQUIREMENT Is not met as evidenced by:</td>
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<td>Based on observation and interview, it was determined the facility failed to ensure food was</td>
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<td>prepared, stored and served under sanitary conditions as evidenced by the presence of</td>
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<td>sticky, grease and food on the small mixer, a large amount of black carbon build up on the</td>
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<tr>
<td></td>
<td>cook stove with dirt and grease down the side of stove</td>
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<td>Ninety-two (92) of 98 residents received meals from the kitchen.</td>
<td></td>
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<tr>
<td></td>
<td>The finding included:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Observations in the kitchen on 7/11/11 at 10:35 AM, revealed sticky, grease and food on the</td>
<td></td>
</tr>
<tr>
<td></td>
<td>small mixer, a large amount of black carbon build up on the cook stove with dirt and grease</td>
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<tr>
<td></td>
<td>down the side of stove.</td>
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<tr>
<td></td>
<td>Observations of the large amount of black carbon build up on the cook stove and the dirt and</td>
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<tr>
<td></td>
<td>grease down the side of stove was still present on 7/12/11 at 11:13 AM and on 7/13/11 at 8:10</td>
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<td></td>
<td>AM.</td>
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<td></td>
<td>2. Observations in kitchen on 7/11/11 at 4:20 PM, revealed the maintenance man brought ice</td>
<td></td>
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<td></td>
<td>into the kitchen without a hair covering and the milk man brought milk in without wearing a hair</td>
<td></td>
</tr>
<tr>
<td></td>
<td>covering.</td>
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<tr>
<td></td>
<td>During an interview in the main dining room on 7/12/11 at 5:45 PM, Resident #10 and Random</td>
<td></td>
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<tr>
<td></td>
<td>Resident #9 stated, &quot;Staff in the kitchen don't wear hair nets when you're not here...&quot;</td>
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<tr>
<td>F 456</td>
<td>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE</td>
<td>07/15/11</td>
</tr>
<tr>
<td>F 371</td>
<td>All Dietary Staff were in-serviced on cleaning of all dietary equipment after use, including</td>
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<tr>
<td></td>
<td>stove and mixer. All staff and vendors were in-serviced on wearing of hairnets prior to</td>
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<tr>
<td></td>
<td>entering the dietary department. Hairnet policy was posted at the doors of each entrance to the</td>
<td></td>
</tr>
<tr>
<td></td>
<td>kitchen.</td>
<td></td>
</tr>
<tr>
<td>F 456</td>
<td>Hairnets will be made available to all staff and vendors upon entering the dietary department</td>
<td>07/11/11</td>
</tr>
<tr>
<td></td>
<td>on 7/15/11. Department cleaning schedule was revised on 07/15/11, to include stove and mixer</td>
<td></td>
</tr>
<tr>
<td></td>
<td>cleaning after use.</td>
<td></td>
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<tr>
<td>F 456</td>
<td>Dietary manager or designee will check two times a week to ensure proper use and placement of</td>
<td></td>
</tr>
<tr>
<td></td>
<td>hairnets. Dietary manager or designee will monitor daily for sanitation of equipment and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>initialing of the cleaning schedule.</td>
<td></td>
</tr>
<tr>
<td>ID PREFIX TAG</td>
<td>ID TAG</td>
<td>ACTION</td>
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<tr>
<td>SS=D</td>
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<tr>
<td>F 456</td>
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<tr>
<td>F 456</td>
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</tbody>
</table>

**OPERATING CONDITION**

The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

This REQUIREMENT is not met as evidenced by:

Based on observation and interview, it was determined the facility failed to maintain the air conditioning units in 1 of 31 (Resident #1) sampled resident rooms and in 1 of 2 (main dining room) dining rooms. The facility failed to maintain 1 of 3 (Kitchen) ice machines and the commode in 1 of 69 (room 32) resident rooms. The findings included:

1. Observations in Resident #1's room on 7/1/11 at 11:05 AM, revealed the cover over the air conditioner controls was missing.
   During an interview in Resident #1's room on 7/1/11 at 11:05 AM, Resident #1 stated, "...told Administrator he would not come in around the window..."

2. During the group interview, in the activity room on the new wing, on 7/12/11 at 9:30 AM, 2 of 9 (Resident #10 and Random Resident (RR) #4) alert and oriented residents attending the group stated it was hot in the dining room all the time.

Observations in the main dining room on 7/12/11 at 8:00 PM, revealed Resident #10, RR #4, RR #8 and RR #11 had very red cheeks. RR #4 stated "It's hot in here."

Observations in the main dining room on 7/12/11 with the surveyors thermometer the following air...
### F 456

**Continued From page 75**

Room temperatures were obtained:

- **a.** At 6:00 PM, the east side of the dining room was 84 degrees Fahrenheit (F).
- **b.** At 6:15 PM - the temperature in the dining room was 87 degrees.
- **c.** At 6:15 PM - the west side of the dining room was 88 degrees F.

During an interview in the main dining room on 7/12/11 at 6:10 PM, the Administrator was shown the air conditioner units with loose casings putting out small amount of air when set on high. The Administrator stated, "...they [air conditioners] are doing all they can do... could be frozen up..."

During an interview outside the social worker's office on 7/12/11 at 9:30 PM, the Administrator was asked what he was going to do about the air conditioners in the main dining room. The Administrator stated, "Until the other serviced, don't know what we will do. If it's that hot tomorrow, residents will eat in their rooms..."

3. **Observations in the kitchen on 7/11/11 at 10:35 AM, revealed a maintenance staff member brought in a bag of ice.**

Observations in the main dining room on 7/12/11 at 3:00 PM, revealed 12 of 22 babies that contained glasses of iced tea had no ice in the glasses. Resident #15 stated, "Haven't had ice in the tea for as long as I have been here."

Observations in the kitchen on 7/12/11 at 5:45 PM, revealed the ice machine was nearly empty.

During an interview in the kitchen on 7/12/11 at 5:45 PM, the Dietary Manager stated, "...ice..."
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

<table>
<thead>
<tr>
<th>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</th>
<th>PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER</td>
<td>445402</td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**  
SPRING MEADOWS HEALTH CARE CENTER

<table>
<thead>
<tr>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO 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>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>F 456</strong> Continued From page 76 machine broke down for 3 days...“ 4. During an interview in the main hall on 7/15/11 at 10:30 AM, Resident #1 stated, &quot;...going to tell the Administrator that my toilet is running and there is water on the floor... it does this every day...&quot; During an interview in Resident #1's room on 7/15/11 at 10:55 AM, Resident #1 stated, &quot;...told the Administrator and his response was that he would be down in a minute... afraid to go to the bathroom because of the water on the floor... can you tell them to hurry up... I have to go to the bathroom...&quot; 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the environment was clean and sanitary, as evidenced by scarred door facings, doors marked or chipped in 6 of 59 (residents rooms 26, 27, 28, 29 and 30) resident rooms. The findings included: Observations of the facility during the initial tour on 7/11/11 beginnings at 10:30 AM revealed the following: a. Room 26 - Door facing scarred 8 inches on lower portion on right and left from the hall into</td>
<td><strong>F 456</strong></td>
<td>B. Maintenance will check monthly all A/C units in building to ensure all are intact and working properly and repair/replace as necessary. <strong>F 465</strong></td>
<td><strong>07-25-11</strong></td>
</tr>
<tr>
<td><strong>F 465</strong></td>
<td>C. During peak A/C season Maintenance or Administrator will check temp in Dining Room daily (M-F) and adjust as needed to maintain room temperature. <strong>F 465</strong></td>
<td><strong>07-25-11</strong></td>
<td></td>
</tr>
<tr>
<td><strong>F 465</strong></td>
<td>D. Maintenance Director and Administrator will monitor monthly for compliance. <strong>F 465</strong></td>
<td><strong>07-25-11</strong></td>
<td></td>
</tr>
<tr>
<td><strong>F 465</strong></td>
<td><strong>7/27/11</strong></td>
<td><strong>07-25-11</strong></td>
<td></td>
</tr>
<tr>
<td><strong>F 465</strong></td>
<td>A. 1 a. Room 26- Door and door facing will be repaired. b. Room 27- Door facing painted. c. Room 28- Door and door facing painted. d. Room 29- Door facing painted. e. Room 30- Door facing painted.</td>
<td><strong>07-25-11</strong></td>
<td></td>
</tr>
</tbody>
</table>

**STREET ADDRESS, CITY, STATE, ZIP CODE**  
220 STATE ROUTE 76  
CLARKSVILLE, TN 37043  
07/15/2011
Continued From page 77
the room. Lower portion of right door facing was
scarred 8 inches above the door closure entering
the hall from the room.
b. Room 27 - Door facing scarred 8 inches on
lower portion of right and left of door facing from
the hall entering the room.
c. Room 28 - Door facing entering room from hall
paint very scarred on left and right 8 inches.
Lower portion of door facing leading from room to
the hall was scarred on lower left.
d. Room 29 - Door facing entering the room from
the hall, the pain was very scarred on the left
bottom 36 inches and right bottom 6 inches.
e. Room 30 - Door facing scarred 36 inches on
lower portion right and left of door facing from
the hall entering the room.

F 469
483.70(h)(4) MAINTAINS EFFECTIVE PEST
CONTROL PROGRAM

The facility must maintain an effective pest
control program so that the facility is free of pests
and rodents.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was
determined the facility failed to maintain an
environment free of flies or a mouse in 3 of 69
(resident rooms 1, 43 and 44) resident rooms.
The findings included:
1. Observations in resident room 1 on 7/12/11 at
5:00 PM, revealed a fly in the room. The fly
landed on the surveYor while interviewing the
resident in the room.
2. Observations in the hallway outside resident
room 43 on 7/13/11 at 7:55 AM, revealed a
**SPRING MEADOWS HEALTH CARE CENTER**

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 469</td>
<td>Continued From page 78 mouse exiting room 43 and entering room 44. During an interview in the hallway outside resident room 43 on 7/13/11 at 7:53 AM, the Dietary Manager stated, &quot;I saw it [the mouse] ...I'll call maintenance.&quot;</td>
<td>F 469</td>
<td>C. An insect light will be installed on 7/28/11 by extermination company to attract and trap flying insects.</td>
<td>07-28-11</td>
</tr>
<tr>
<td>F 490</td>
<td>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</td>
<td>F 490</td>
<td>D. Housekeeping supervisor and department will continue to monitor for pest to ensure pest free environment.</td>
<td>07-18-11</td>
</tr>
<tr>
<td></td>
<td>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Amended 2657</td>
<td></td>
<td></td>
<td>07-14-11</td>
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</tbody>
</table>

Based on policy review, review of the "Falling Star Program", review of "Event Documentation" forms, medical record review, observation and interview, it was determined the facility failed to be administered in a manner that maintained the highest practicable physical and psychosocial well-being for all residents by failing to ensure residents at risk for falls were adequately supervised and had interventions developed and implemented after each fall for 2 of 20 (Residents #3 and #8) sampled residents identified with falls. Resident #3 was assessed as being at risk for falls. Resident #3 sustained eight falls from 2/3/11 to 7/4/11. Five falls resulted in serious injuries such as lacerations with sutures, one fall sustained a chipped tooth and the last fall on 7/4/11 resulted in a fractured nose. The facility's failure to develop and implement interventions to protect the resident after each of these falls

Res. # #3 – 1:1 Nurse aide began immediately at 1:00pm on 07/14/11 for 30 days to observe B & B patterning, bed and w/c exit attempts and identify possible causes. Will re-evaluate after 30 days and plan accordingly.
### SUMMARY STATEMENT OF DEFICIENCIES

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
</tr>
</thead>
</table>
| F 490         | Continued From page 79

placed Resident #3 in immediate jeopardy as evidenced by repeated falls with serious injuries that required medical interventions and resulted in substandard quality of care.

A conference was held with the Administrator, in the Administrator's office on 7/14/11 at 5:17 PM, to inform him of the surveyors findings that placed Resident #3 in Immediate jeopardy.

The findings included:

The administration failed to identify and address staff competency in developing and implementing interventions after each fall for residents identified as being at risk for falls and adequately supervising residents to prevent falls or injuries from falls for residents. Resident #3 sustained falls and experienced actual harm with injuries requiring medical intervention on 2/13/11, 3/14/11, 3/26/11, 6/10/11, 6/14/11 and 7/4/11. Continued failure of the staff to develop and implement interventions to prevent further injury from falls and provide adequate supervision to prevent injuries resulted in Immediate Jeopardy for Resident #3. Resident #8 fell backwards over back of the chair, hitting his head and shoulders on 6/18/11 sustaining an intracranial hemorrhage. The facility failed to be specific with interventions put in place to prevent falls or injuries from falls. Refer to F280, F282 and F323.

The administration failed to ensure the Quality Assurance Committee established a method for identifying concerns in the facility. Refer to F520.

The Immediate Jeopardy was lifted on 7/15/11 at 5:05 PM and noncompliance still continues at the

### PROVIDER'S PLAN OF CORRECTION

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>F 490</td>
<td>• Order obtained from physician for P/T eval for seating device.</td>
</tr>
<tr>
<td></td>
<td>• Drop seat w/c provided by P/T.</td>
</tr>
<tr>
<td></td>
<td>• Reverse Torso Support while up in chair.</td>
</tr>
<tr>
<td></td>
<td>• Installed Smart Alarm Sensor</td>
</tr>
<tr>
<td></td>
<td>• New fall risk assessment done and Care Plan updated.</td>
</tr>
<tr>
<td></td>
<td>• All patients at risk for falls will be re-assessed by P/T to ensure devices in use are effective and appropriate on 07/14/11.</td>
</tr>
</tbody>
</table>

Resident #8 had fall risk assessment done on 07/14/11 and had 1:1 supervision X 24 hrs. with no w/c or bed exit attempts identified. P/T screened on 07/14/11 to ensure proper devices were in place and recommended ambulation 2 X per day with rolling walker and 2 person assist.

### B. New fall risk assessments were done on all patients on 07/14/11.
### Statement of Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LEC 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>
</tr>
</thead>
<tbody>
<tr>
<td>F480</td>
<td>Continued From page 80 lower scope and severity level of D.</td>
<td>F490</td>
<td>• Audit of fall risk assessment to identify that assessments are completed upon admission, quarterly, and after each fall.</td>
</tr>
<tr>
<td>F520</td>
<td>483.75(c)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</td>
<td>F520</td>
<td>• Identify patients who are Falling Stars on each shift's CNA assignment sheet to increase their awareness of those identified at risk.</td>
</tr>
<tr>
<td></td>
<td>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</td>
<td></td>
<td>• P/T screening after each falls within 72 hours.</td>
</tr>
<tr>
<td></td>
<td>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</td>
<td></td>
<td>• Re-enforce Falling Star Program through in-service.</td>
</tr>
<tr>
<td></td>
<td>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</td>
<td></td>
<td>• Follow Standard Operating Procedure for Falls.</td>
</tr>
<tr>
<td></td>
<td>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</td>
<td></td>
<td>• Within one week the team will network with our resources within the association and our sister facility to get ideas on successful strategies for preventing and dealing with resident falls.</td>
</tr>
</tbody>
</table>

This REQUIREMENT is not met as evidenced by:
Amended 2557

Based on policy review, review of the "Falling Star Program", review of "Event Documentation" forms, medical record review, observation and interview, it was determined the facility's...
C. On 07/14/11 the CNA doing 1:1 was educated as to exactly why she was doing 1:1 with Resident #3 (to observe bed and reposition attempts, B&B patterning, and other possible causes).

3-11 and 11-7 shift staff was in-serviced by the Administrator on Fall Program and have the patients at risk pointed out to them on their assignment sheets. All 7-3 shift, weekend shifts, and personnel off duty were in-serviced upon their next working shift.

- We will audit Fall Risk Assessments to ensure they are done timely upon admission, quarterly, and after each fall.
- All staff will be in-serviced by D.O.N. or supervisor upon hire, annually, and as necessary with Fall Program and Procedure.
- Fall Risk Committee will meet weekly in separate meeting to review incidents of falls and implement appropriate interventions/devices. Falls Risk Committee consists of O/T, P/T, MDS, Restorative CNA and QA Nurse. Weekly this committee will address every fall and evaluate devices and the effectiveness of interventions. And meeting will documented in QA Fall Team Minutes. All falls will continue to be reviewed and addressed every morning at which time we will review incident documentation, devices used, effectiveness and appropriateness. We will check to see if resident has
had previous falls and how many for the past 180 days. Nursing and CNA Care Plans will be updated to reflect changes in interventions. Nursing documentation X 3 days after fall will be reviewed for implementation, effectiveness, and appropriateness.

D. QA Nurse or designee will perform audits. Fall Risk Committee and Rehab Manager or designee will monitor to ensure audits are done weekly and as needed. Results will be reported to Administrator or D.O.N. designee. We will follow disciplinary process of verbal warning, written warning, suspension leading to possible termination.
Charge Nurse, Nurse Supervisor, D.O.N. designee and Administrator will monitor Nursing's performance of implementing the intervention for the fall. The Human Resources Director will monitor through existing corporate compliance program and report any unresolved concerns regarding administration's failure to resolve and follow-up any grievances.
**F 520 Continued From page 81**

Administrative staff failed to identify and address quality of care issues such as failure to ensure adequate supervision of residents and failure to ensure adequate interventions were developed and implemented to prevent falls and injuries from falls for 2 of 20 (Residents #3 and 8) sampled residents identified with falls. Resident #3 was assessed as being at risk for falls. Resident #3 sustained eight falls from 2/3/11 to 7/4/11. Five falls resulted in serious injuries such as lacerations with sutures, one fall sustained a chipped tooth and the last fall on 7/4/11 resulted in a fractured nose. The failure of the Quality Assurance (QA) committee to identify and address these concerns resulted in actual harm to Resident #3, placed Resident #3 in immediate jeopardy as evidenced by repeated falls with serious injuries that required medical interventions, and resulted in substandard quality of care.

A conference was held with the Administrator, in the Administrator's office on 7/14/11 at 5:17 PM, to inform him of the surveyors findings that placed Resident #3 in immediate jeopardy.

The findings included:

During an interview in the QA Nurse's office on 7/15/11 at 5:45 PM, the QA Nurse did not identify falls as a problem identified by the QA committee. The QA Nurse stated problems may be identified by anyone on the QA committee, but could not provide an established method for identifying QA concerns.

The QA committee staff failed to identify and address the staff competency in developing and

### F 520

<table>
<thead>
<tr>
<th>ID</th>
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<th>7/14/11</th>
<th>F520</th>
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<tbody>
<tr>
<td>A.</td>
<td>Immediately after each fall, resident is assessed and treated for any injuries. Nurse will try to determine root cause, address individual needs, initiate Bowel and Bladder Assessment, complete Fall Risk Assessment and implement appropriate interventions per Standard Operating Procedure for Falls. Resident is also placed on Falling Star Program after initial fall. Res. #3 - 1:1 Nurse aide began immediately at 1:00pm on 07/14/11 for 30 days to observe B &amp; B patterning, bed and w/c exit attempts and identify possible causes. Will re-evaluate after 30 days and plan accordingly.</td>
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**Note:** The text continues on the next page.
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(x1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: 445402

(x2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(x3) DATE SURVEY COMPLETED: 07/15/2011

NAME OF PROVIDER OR SUPPLIER
SPRING MEADOWS HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
220 STATE ROUTE 26
CLARKSVILLE, TN 37043

(x4) ID PREFIX TAG
F 520

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

ID PREFIX TAG
F 520

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(x5) COMPLETION DATE

F 520

- New fall risk assessment done and Care Plan updated.
- All patients at risk for falls will be re-assessed by P/T to ensure devices in use are effective and appropriate on 07/14/11.

Resident #8 had fall risk assessment done on 07/14/11 and had 1:1 supervision X 24 hrs. with no w/c or bed exit attempts identified. P/T screened on 07/14/11 to ensure proper devices were in place and recommended ambulation 2 X per day with rolling walker and 2 person assist.

B. New fall risk assessments were done on all patients on 07/14/11.

- Audit of fall risk assessment to identify that assessments are completed upon admission, quarterly, and after each fall.
- Identify patients who are Falling Stars on each shift's CNA assignment sheet to increase their awareness of those identified at risk.
- P/T screening after each fall within 72 hours.
- Re-enforce Falling Star Program through in-service.
- Follow Standard Operating Procedure for Falls.
C. On 07/14/11 the CNA doing 1:1 was educated as to exactly why she was doing 1:1 with Resident #3 (to observe bed and w/e exit attempts, D&B patterning, and other possible causes).

3-11 and 11-7 shift staff was in-serviced by the Administrator on Falling Star Program and have the patients at risk pointed out to them on their assignment sheets. All 7-3 shift, weekend shifts, and personnel off duty were in-serviced upon their next working shift.

- We will audit Fall Risk Assessments to ensure they are done timely upon admission, quarterly, and after each fall.
- All staff will be in-serviced by D.O.N. or supervisor upon hire, annually, and as necessary with Falling Star Policy and Procedure.
- Fall Risk Committee will meet weekly in separate meeting to review incidents of falls and implement appropriate interventions/devices. Falls Risk Committee consists of O/T, P/T, MDS, Restorative CNA and QA Nurse. Weekly this committee will address every fall and evaluate devices and the effectiveness of interventions. And meeting will documented in QA Fall Team Minutes. All falls will continue to be reviewed and addressed every morning at which time we will review incident documentation, devices used, effectiveness and appropriateness. We will check to see if resident has
had previous falls and how many for the past 180 days. Nursing and CNA Care Plans will be updated to reflect changes in interventions. Nursing documentation X 3 days after fall will be reviewed for implementation, effectiveness, and appropriateness.

D. QA Nurse or designee will perform audits. Fall Risk Committee and Rehab Manager or designee will monitor to ensure audits are done weekly and as needed. Results will be reported to Administrator or D.O.N. designee. We will follow disciplinary process of verbal warning, written warning, suspension leading to possible termination. Charge Nurse, Nurse Supervisor, D.O.N. designee and Administrator will monitor Nursing's performance of implementing the intervention for the fall. The Human Resources Director will monitor through existing corporate compliance program and report any unresolved concerns regarding administration's failure to resolve and follow-up any grievances.