This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding.

1. On 3/15/2011 an outside plumbing company came in and evaluated the hot water system. This in turn adjusted and increased water temperatures in rooms, 100, 101, 109, 119, 118, 117, 118, 119, 211, 213, 301, 300, 310, 312, 314, 315, 316, 360, 400, 401, 403, 404, 407, 409, 410. Water temperatures were checked by maintenance director on 3/15/2011. On 3/21/2011 the entire system was evaluated by the installer and water temperatures were checked by the maintenance director.

2. All residents have the potential to be affected by this citation. Audit was completed by maintenance director of temperatures in resident rooms and shower rooms on 3/21/2011.

3. The maintenance director/manager on duty was in servied by the administrator on 3/24/2011 on recording of water temperatures.

ORATORY DIRECTORS OR PROVIDERS/REPRESENTATIVES SIGNATURE

Administrator

Deficiency Statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patient. (See Instructions.) Except for nursing homes, the findings stated above are disclosed to 90 days from the date of survey to the facility. For nursing homes, the above findings and plans of correction are disclosed to 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued gram participation.
<table>
<thead>
<tr>
<th>ID</th>
<th>Statement of Deficiencies</th>
<th>Corrective Plan of Correction</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>166</td>
<td>Continued From page 1</td>
<td>4. Water temperatures in residents rooms will be checked daily times 7 days, 5 times a week times 1 week, 3 times a week times 2 weeks, 2 times a week times 1 month, 1 times a week times 1 month and for until 100% compliance obtained by the Maintenance Director and/or manager on duty. Resident council and 4 random resident interview regarding temperatures in rooms and shower rooms will be held weekly times 1 month then bi-weekly for 2 months. Results of audits will be reported to the Quality Assurance committee by the administrator X3 months or until 100% compliance obtained. Members of the Quality Assurance Committee are the Administrator, Medical Director, Director of Nursing, Social Services, Activities Director, Dietitian, Minimum Data Set RN, Medical Records, and Rehab Manager.</td>
<td></td>
</tr>
</tbody>
</table>

1. Continued From page 1

degrees $F$ at 5:15 PM.

b. Room 101 - 100 degrees $F$ at 10:55 AM.

c. Room 109 - 99 degrees $F$ at 11:00 AM.

d. Room 119 - 100 degrees $F$ at 11:19 AM.

e. Room 118 - 100 degrees $F$ at 11:22 AM.

f. Room 116 - 98 degrees $F$ at 5:18 PM.

g. Room 110 - 100 degrees $F$ at 5:20 PM.

Observations of the hot water temperatures on the 100 hall on 3/15/11 revealed the following:

a. Room 101 - 86 degrees $F$ at 7:48 AM and 95 degrees $F$ at 4:45 PM.

b. Room 115 - 100 degrees $F$ at 7:50 AM.

c. Room 118 - 100 degrees $F$ at 7:50 AM.

d. Room 112 - 100 degrees $F$ at 4:50 PM.

Observations of the hot water temperatures on the 100 hall on 3/19/11 revealed the following:

a. Room 107 - 104.5 degrees $F$ at 9:55 AM.

b. Room 103 - 105 degrees $F$ at 9:58 AM.

4. Observations of the hot water temperatures on the 200 hall on 3/14/11 revealed the following:

a. Room 209 - 92 degrees $F$ at 11:25 AM.

b. Room 207 - 88 degrees $F$ at 11:30 AM.

c. Room 205 - 100 degrees $F$ at 11:40 AM.

Observations of the hot water temperatures on the 200 hall on 3/15/11 revealed the following:

a. Room 200 - 90 degrees $F$ at 10:40 AM and 4:45 PM.

b. Room 201 - 80 degrees $F$ at 10:45 AM and 88 degrees $F$ at 4:50 PM.

c. Room 209 - 88 degrees $F$ at 10:33 AM and 82 degrees $F$ at 4:55 PM.

d. Room 211 - 90 degrees $F$ at 10:37 AM and 4:53 PM.

Observations of the hot water temperatures on the 200 hall on 3/19/11 revealed the following:

a. Room 212 - 98 degrees $F$ at 9:50 AM and 4:55 PM.

b. Room 210 - 100 degrees $F$ at 10:45 AM and 88 degrees $F$ at 4:50 PM.

c. Room 209 - 88 degrees $F$ at 10:33 AM and 82 degrees $F$ at 4:55 PM.

d. Room 211 - 90 degrees $F$ at 10:37 AM and 4:53 PM.
Continued From page 2

5. Observations of the hot water temperatures on the 300 hall on 3/14/11 revealed the following:
   a. Room 301 - 90 degrees F at 10:18 AM.
   b. Room 310 - 80 degrees F at 11:05 AM.
   c. Room 312 - 79 degrees F at 10:52 AM.
   d. Room 314 - 85 degrees F at 10:45 AM.
   e. Room 315 - 96 degrees F at 10:50 AM.
   f. Room 316 - 80 degrees F at 10:45 AM.

Observations of the hot water temperatures on the 300 hall on 3/15/11 revealed the following:
   a. Room 300 - 82 degrees F at 4:52 PM.
   b. Room 301 - 76 degrees F at 4:52 PM.
   c. Room 314 - 84 degrees F at 4:52 PM.
   d. Room 316 - 82 degrees F at 4:52 PM.

Observations of the hot water temperatures on the 300 hall on 3/16/11 revealed the following:
   a. Room 301 - 76 degrees F at 8:35 AM and 100 degrees F at 10:13 AM.
   b. Room 305 - 97.3 degrees F at 8:38 AM.
   c. Room 316 - 95.9 degrees F at 8:40 AM and 87.4 degrees F at 10:13 AM.

6. Observations of the hot water temperatures on the 400 hall on 3/14/11 revealed the following:
   a. Room 400 - 94 degrees F at 11:20 AM.
   b. Room 401 - 108 degrees F at 10:15 AM.
   c. Room 403 - 100 degrees F at 10:53 AM.
   d. Room 405 - 84 degrees F at 10:56 AM.
   e. Room 407 - 96 degrees F at 11:05 AM.
   f. Room 409 - 98 degrees F at 11:15 AM.

Observations of the hot water temperatures on the 400 hall on 3/15/11 revealed the following:
<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 LEGAL IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 166</td>
<td></td>
<td></td>
<td>Continued From page 3</td>
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<td></td>
<td></td>
<td></td>
<td>a. Room 401 - 92 degrees F at 4:55 PM.</td>
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<td>b. Room 405 - 86 degrees F at 4:51 PM.</td>
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<td>c. Room 410 - 102 degrees F at 4:59 PM.</td>
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<td>7. During the group interview in the conference room on 3/14/11 at 2:30 PM, 9 of 9 alert and oriented residents complained of cold water temperatures.</td>
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<td>During an interview in the Administrator’s office on 3/15/11 at 5:00 PM, the Administrator was asked how long there had been problems with the hot water temperatures. The Administrator stated, “Just got a new system last week, fully operational tankless water system. Had an older boiler system... time to replace. Supposed to be continuous heat.”</td>
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<td>During an interview in the Administrator’s office on 3/15/11 at 5:00 PM, the Maintenance Supervisor was asked about the tankless system. The Maintenance Supervisor stated, ‘...circulation problem, circulates [water] throughout the building. One of circulation pumps not working, been hearing from the residents today as well...’</td>
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<td>During an interview in the 400 hall shower room on 3/16/11 at 7:50 AM, the Maintenance Supervisor stated, “One water heater igniter was malfunctioning so dumping cold water into hot...”</td>
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<td>During the quality assurance (QA) interview in the Administrator’s office on 3/16/11 at 2:40 PM, the Administrator was asked about problems the facility had identified. The Administrator stated cold water had been a concern of staff and residents since January (2011) and was discussed at the February 16th (2011) QA meeting. The old boiler wasn’t reliable which is</td>
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</tbody>
</table>
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X) PROVIDER/Supplier/CLA Identification Number:**

**445433**

**(X) PROVIDER NAME:**

**GRACE HEALTHCARE OF CLARKSVILLE**

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

**111 USSEY ROAD CLARKSVILLE, TN 37043**

**DATE SURVEY COMPLETED:**

**03/16/2011**

**(X) ID TAG**

<table>
<thead>
<tr>
<th>ID PREFIX</th>
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</thead>
<tbody>
<tr>
<td>F 166</td>
</tr>
<tr>
<td>F 246</td>
</tr>
</tbody>
</table>

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

**F 166 Continued From page 4 why new tankless system was put in March (2011).**

**F 246 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES**

A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, review of a tray card, observation, and interview, it was determined the facility failed to accommodate individual needs during 1 of 2 (lunch) dining observations.

The findings included:

Medical record review for resident #14 documented an admission date of 1/11/11 with diagnoses of Blindness Both Eyes and Mental Retardation. A nutritional risk review and assessment dated 12/28/11 documented...

...Adaptive device plate guard... Summary of nutritional assessment... need for assistance w [with] eating (rt [related to] limited vision)...

Observations in the dining room on 3/15/11 beginning at 12:15 PM revealed the tray cart that was placed beside of Resident #14’s plate documented that Resident #14 required a plate guard.

**ID TAG**

<table>
<thead>
<tr>
<th>F 166</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 246</td>
</tr>
</tbody>
</table>

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

**F 166**

- Resident #14 was assessed by the Director of Nursing on 3/15/2011. Resident was assessed by the physician on 3/23/2011 with no adverse outcomes noted.
- Residents with adaptive equipment and who require assistance during meal times have the potential to be ineffective. An audit was completed by the Assistant Director of Nursing and/or Nursing Supervisor to determine who had adaptive equipment and who required assistance beginning 3/23/2011-3/29/2011.
- Licensed nurses and certified nursing assistants were in-serviced between 3/23/2011-3/29/2011 by the Director of Nursing and/or Nursing supervisor on ensuring that residents are provided assistance when needed and that adaptive equipment is in place. Dietary department was in-serviced by the Dietary Manager on validating adaptive equipment in place as trays leave dining room starting 3/23/2011-3/29/2011.

**F 246**

- Residents with adaptive equipment and who require assistance with dining will be audited during random meal times 3 times a week times 3 weeks, then 3 times a week times 3 weeks, then 3 times a week times 3 months or until 100% compliance obtained by the Director of Nursing and/or Nursing Supervisor. The findings will be reported to the Quality Assurance Committee times 3 months or until 100% compliance is achieved by the Director of Nursing. The Quality Assurance Committee consists of the Administrator, Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, Social Services Department, MDS Team, Maintenance Department, Environmental Services, Medical Records, Rehabilitation Department, Activities, and Medical Director.
Continued from page 5

Observations in the dining room on 3/15/11 beginning at 12:15 PM revealed Resident #14 was served a meal of liver, green beans, tomato slices, roll, and sweet potato pie. Resident #14's plate did not have a plate guard. Resident #14 had a clothing protector over her chest that fell onto the floor. Resident #14 ate her meal very quickly, taking very large bites, using her fingers to pick up food and put it in her mouth, then she rubbed her fingers through her hair and on her face. When Resident #14 needed to wipe her mouth, she grabbed her shirt between the neck and end of the sleeve and wiped her mouth. Nurse #3 was sitting at the table with Resident #14 and two other residents. Nurse #3 was never observed to cue Resident #14 to slow down, take smaller bites, or offer her another clothing protector.

During an interview in the dining room on 3/15/11 at 1:20 PM Nurse #3 and Certified Nursing Assistant (CNA) #1 were asked if they knew if Resident #14 should have needed anything else. Nurse #3 stated she did not know. CNA #1 stated, Resident #14 probably needed a clothing protector. When the surveyor asked if Resident #14 needed a plate guard, neither Nurse #3 nor CNA #1 know she needed one.

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the
F 280: Continued From page 6

A 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 residents' 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:

1. Medical record review for Resident #12 documented an admission date of 4/29/09 with a readmission date of 6/4/09 with diagnoses of End Stage Renal Disease (ESRD), Diabetes Mellitus (DM) II, Hypertension (HTN), and Congestive Heart Failure (CHF). Review of the physician's orders dated 3/1/11 documented, "...RESIDENT TO RECEIVE DIALYSIS at the [named dialysis facility] EVERY MON [Monday], WED [Wednesday] AND FRI [Friday]." Review of the care plan dated 9/29/09 documented, "...Assess for bleeding and notify MD [Medical Doctor] PRN [as needed] bleeding at access site." The care plan did not include interventions to stop emergency bleeding.

2. Residents receiving dialysis have the potential to be affected by this citation. An audit of the dialysis care plans for emergency interventions was completed by the Director of Nursing and/or Nursing supervisor on 3/23/2011.

3. Licensed nurses were in-serviced by the Director of Nursing and/or Assistant Director of Nursing on 3/23/2011-3/25/2011 on updating and writing dialysis care plan.

4. Dialysis care plans will be audited for completeness 1 times a week times 3 months and/or until 100% compliance obtained by the Director of Nursing and/or Nurse Supervisor. Results of audits will be reported to the Quality Assurance committee by the Director of Nursing times 3 months or until 100% compliance obtained. Members of the Quality Assurance Committee are the Administrator, Medical Director, Director of Nursing, Social Services, Activities Director, Dietary Manager, Minimum Data Set RN, Medical Records, and Rehab Manager.
F 280  Continued From page 7


During an interview in the minimum data set (MDS) coordinator’s office on 3/16/11 at 10:50 AM, the MDS coordinator was asked about interventions for emergency bleeding. The MDS coordinator stated, "...Monitor for bleeding, apply pressure, and call the doctor."

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

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 medical record review, review of a tray card, observation, and interview, it was determined the facility failed to ensure the care plan was followed for 1 of 20 (Resident #14) sampled residents observed during 1 of 2 (lunch) dining observations.

The findings included:

<table>
<thead>
<tr>
<th>ID</th>
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<th>TAG</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 280</td>
<td></td>
<td></td>
<td>F 282</td>
<td></td>
<td></td>
<td>4/8/11</td>
</tr>
</tbody>
</table>

1. Resident #14 was assessed by the Director of Nursing on 3/15/2011. Resident was assessed by the physician on 3/23/2011 with no adverse outcomes noted.

2. Residents with adaptive equipment and who require assistance during meal times have the potential to be effective. An audit was completed by the Assistant Director of Nursing and/or Nursing Supervisor to determine who had adaptive equipment and who required assistance beginning 3/23/2011-3/25/2011.

3. Licensed nurses and certified nursing assistance were in-serviced between 3/23/2011-3/29/2011 by the Director of Nursing and/or Nursing supervisor on ensuring that residents are provided assistance when needed and that adaptive equipment is in place. Dietary department was in-serviced by the Dietary Manager on validating adaptive equipment.
Continued From page 8

Medical record review for Resident #14 documented an admission date of 1/11/11 with diagnoses of Blindness of Both Eyes and Mental Retardation. Review of the admission care plan documented "...Problem Onset 1/1/11 ADL [activities of daily living] deficit... Approaches... finger foods to allow resident dignity issues of feeding herself as resident accepts... plate guard on plate for all meals..."

Observations in the dining room on 3/15/11 beginning at 12:15 PM revealed the tray card that was placed beside of Resident #14's plate documented that Resident #14 required a plate guard.

Observations in the dining room on 3/15/11 beginning at 12:15 PM revealed Resident #14 was served a meal of liver, green beans, tomato slices, roll, and sweet potato pie. Resident #14's plate did not have a plate guard. Resident #14 had a clothing protector over her chest that fell onto the floor. Resident #14 ate her meal very quickly, taking very large bites, using her fingers to pick up food and put it in her mouth, then she rubbed her fingers through her hair and on her face. When Resident #14 needed to wipe her mouth, she grabbed her shirt between the neck and end of the sleeve and wiped her mouth. Nurse #3 was sitting at the table with Resident #14 and two other residents. Nurse #3 was never observed to cue Resident #14 to slow down, take smaller bites, or offer her another clothing protector. Nurse #3 was not observed to offer Resident #14 any finger foods.

During an interview in the dining room on 3/15/11 at 1:20 PM Nurse #3 and Certified Nursing Assistant (CNA) #1 were asked if they knew if


Residents with adaptive equipment and who require assistance with dining will be audited during random meal times 5 times a week times 2 weeks, then 3 times a week times 3 months or until 100% compliance obtained by the Director of Nursing and/or Nursing Supervisor. The findings will be
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
<th>(x2) MULTIPLE CONSTRUCTION</th>
<th>(x3) DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>445433</td>
<td></td>
<td>03/16/2011</td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

GRACE HEALTHCARE OF CLARKSVILLE

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

111 USSEERY ROAD
CLARKSVILLE, TN 37043

**SUMMARY STATEMENT OF DEFICIENCIES**

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

<table>
<thead>
<tr>
<th>ID</th>
<th>PRECISION 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 282</td>
<td>Continued From page 8</td>
<td>Resident #14 should have needed anything else. Nurse #3 stated she did not know. CNA #1 stated, Resident #14 probably needed a clothing protector. When the surveyor asked if Resident #14 needed a plate guard, neither Nurse #3 nor CNA #1 knew she needed one.</td>
<td>4/8/11</td>
</tr>
<tr>
<td>F 309</td>
<td>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</td>
<td>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</td>
<td>4/8/11</td>
</tr>
</tbody>
</table>

This REQUIREMENT is not met as evidenced by:

- Based on medical record review, review of a tray card, observations and interviews, it was determined the facility failed to document interventions for lack of a bowel movement for 3 of 24 (Residents #3, 8 and 9) sampled residents and failed to follow physician's orders for a plate guard during dining for 1 of 24 (Resident #14) sampled residents.

The findings included:

1. Medical record review for Resident #3 documented an admission date of 9/10/09 with diagnoses of Nuclear Cataract, Alzheimer's Disease, Senile Depression, Hypertension, Osteoarthrosis, Osieroparasis and Muscle Weakness. Review of the physician's standing orders dated 12/8/10 documented, "...MOM [mill of magnesia] 30 cc [cubic centimeters] po [by
### F 309 Continued From page 10

*Continued from page 10*

*continued from page 10*

Review of the bowm movement (BM) detail sheet revealed there was no BM documented for Resident #3 from 1/6/11 through 1/13/11.

2. Medical record review for Resident #3 documented an admission date of 7/8/08 with diagnoses of Senile Dementia, Hypertension, Emphysema, Peripheral Neuropathy and Renal Failure. Review of the physician's standing orders dated 6/22/10 documented, "...MOM 30 cc po PRN. Review of the BM detail sheets revealed there were no BMs documented for Resident #8 from 12/1/10-12/5/10, from 12/28/10-1/9/11, 1/30/11-2/3/11 and from 3/3/11-3/7/11.

3. Medical record review for Resident #8 documented an admission date of 6/20/10 and a readmission date of 2/18/11 with diagnoses of Cellulitis, Pneumonia, Senile Dementia, Diabetes Mellitus Type 2, Hypertension and Muscle Weakness. Review of the physician's standing orders dated 12/8/10 documented, "...MOM 30 cc po PRN. Review of the BM detail sheets revealed no BMs documented for Resident #8 from 12/1/10-12/5/10, from 12/28/10-1/24/10, from 1/1/11-1/10/11, from 1/17/11-1/23/11 and from 3/5/11-3/11/11.

During an interview in the conference room on 3/15/11 at 8:00 AM, the Director of Nursing (DON) stated, "I reviewed the nurses notes and don't see that anything [interventions for no BM] was given during those days." The DON was asked if the resident had a bowel movement during this time, the DON stated, "Not that I can tell..."

4. Medical record review for Resident #14
<table>
<thead>
<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID 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 309</td>
<td>Continued From page 11 documented an admission date of 1/11/11 with diagnoses of Blindness Both Eyes and Mental Retardation. Review of a physician's order on 3/11/11 documented, &quot;...send plate guard on plate for each meal...&quot; Review of Resident #14's tray card documented &quot;...plt [plate] grd [guard]...&quot; Observations in the dining room on 3/15/11 beginning at 12:50 PM, revealed Resident #14 was served lunch meal without a plate guard. During an interview in the dining room on 3/15/11 at 1:20 PM, Nurse #5 was asked about Resident #14's plate guard. Nurse #5 stated she was unaware that Resident #14 required a plate guard.</td>
<td>F 309</td>
<td>F 309</td>
<td>03/16/2011</td>
</tr>
<tr>
<td>F 322</td>
<td>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on policy review, review of the &quot;MEDICATION ADMINISTRATION VIA ENTERAL TUBES&quot; provided by the American Society of Consultant Pharmacists, medical record review, observation, and interview, it was determined the facility failed to ensure staff</td>
<td>F 322</td>
<td>F 322</td>
<td>4/8/11</td>
</tr>
</tbody>
</table>

1. Random Resident #1 was assessed by the Director of Nursing on 3/17/2011 with no adverse outcomes noted. Random Resident #1 was assessed by their physician on 3/23/2011 with no adverse outcomes noted. Nurse #1 was in service by the Director of Nursing on 3/17/2011.

2. All residents who have an enteral tube have the potential to be affected by this citation. An audit of residents with enteral tubes was completed by 3/23/2011 by the Assistant Director of Nursing and/or Nursing Supervisor.

3. Licensed nurses were in-service beginning 3/17/2011-3/23/2011 by the Director of Nursing and/or Nursing Supervisor on proper medication administration through an enteral tube.
F 322  Continued From page 12

provided care and services according to their policy for Percutaneous Endoscopy Gastrostomy (PEG) tube for 1 of 3 Random Residents (RR #1).

The findings included:

Review of the facility's "Administering Medications through an Enteral Tube" policy documented, "The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube... 17... gastrostomy tubes, check placement and gastric contents: a. Attach 50 to 60 ml [milliliters] syringe containing approximately 10cc [cubic centimeters] air. b. Auscultate the abdomen while injecting the air from the syringe into the tubing. c. Listen for "whooshing" sound to check placement of the tube in the stomach. d. Pull back gently on the syringe to aspirate stomach content... 20. Administer medication by gravity flow..."

Review of the "MEDICATION ADMINISTRATION VIA ENTERAL TUBES" provided by the American Society of Consultant Pharmacists documented, "PROCEDURES... Put 15- to 30ml of tap water in syringe and flush tubing using gravity flow... Pour dissolved/diluted medication in syringe and unclamp tubing, allowing medication to flow by gravity..."

Medical record review for RR #1 documented an admission date of 12/28/09 with diagnoses of Prostate Cancer, Failure to Thrive, Senile Dementia, Gastrostomy, Congestive Heart Failure, and Hypertension. Review of a physician's order dated 3/1/11 documented, "...COREG 3.125MG [milligrams] TAKE 1 TABLET PER TUBE 2 TIMES DAILY... ISORDIL 10 MG... TAKE 1 TABLET PER TUBE 3 TIMES
<table>
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<tr>
<th>ID</th>
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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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<tbody>
<tr>
<td>F 322</td>
<td></td>
<td></td>
<td>Continued From page 13 DAILY... ARICEPT... 10MG TAKE 1 TABLET PER TUBE 3 TIMES DAILY... ZOCOR 5 MG... TAKE 1 TABLET PER TUBE AT BEDTIME... FLUSH W [with] / 30 ML H2O [water] BEFORE AND AFTER MEALS [medications]...</td>
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<tr>
<td>F 328</td>
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<td>483.26(k) TREATMENT/CARE FOR SPECIAL NEEDS</td>
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Observations in RR #1's room on 3/14/11 at 4:50 PM, revealed RR #1 lying in bed. Nurse #1 opened the port of the PEG tube, placed the syringe in the tube and aspirated for stomach contents. Nurse #1 removed the syringe and rinsed it with water. Nurse #1 then placed the syringe into the tube and pushed 30 mL of H2O through the tube to flush. Nurse #1 dissolved the meds in H2O, poured the meds into the syringe and pushed them through the tube to administer. Nurse #1 then poured 30 mL of H2O into the tube and pushed through the tube to flush. Nurse #1 did not follow the facility's policy to auscultate to check for tube placement and did not administer the flushes or meds by gravity flow.

During an interview in the conference room on 3/16/11 at 10:50 AM, the Director of Nursing (DON) was asked what was the procedure to administer medications through a PEG tube. The DON stated, "...Should place the syringe in the tubing then administer the meds by gravity."

Resident #18 was assessed by the Director of Nursing on 3/17/2011. The physician was notified on 3/17/2011 with no new orders. Resident #3 was assessed by the Director of Nursing on 3/17/2011. The physician was notified on 3/17/2011 with no new orders.
**Respiratory care; Foot care; and Prostheses.**

This **REQUIREMENT** is not met as evidenced by:

- Based on policy review, medical record review, observations, and interview, it was determined the facility failed to ensure oxygen (O2) was administered at the rate prescribed by the physician for 1 of 6 (Resident #18) sampled residents receiving O2 and failed to ensure O2 was in the portable O2 tank in use for Random Resident (RR #3).

The findings included:

1. Review of the facility's oxygen administration policy documented, "...Adjust the oxygen delivery device... proper flow of oxygen is being delivered... Check the... tank... to be sure they are in good working order... Observe the resident... periodically... to be sure oxygen is being tolerated..." 


Observations in Resident #18's room on 3/16/11 at 8:30 AM and 1:35 PM revealed Resident #18 receiving O2 per binal sal cannula at a rate of 3 L/MIN.
**NAME OF PROVIDER OR SUPPLIER:** GRACE HEALTHCARE OF CLARKSVILLE

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<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>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 328</td>
<td>Continued From page 15: Observations in the 100 hall on 3/16/11 at 1:20 PM, revealed Resident #18 receiving O2 per binalas cannula at a rate of 3 L/MIN per portable O2 tank.</td>
<td>F 328</td>
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<td>During an interview in Resident #18's room on 3/16/11 at 1:35 PM, the Assistant Director of Nursing (ADON) confirmed Resident #18 was receiving O2 per binalas cannula at 3 L/MIN.</td>
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<td>During an interview in the human resource office on 3/16/11 at 1:40 PM, the ADON confirmed Resident #18's current physician's order for O2 was for the O2 to be administered at 1-2L/MIN. The ADON confirmed Resident #18's O2 was being administered at 3L/MIN.</td>
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<td>3. Medical record review for RR #3 documented an admission date of 9/15/08 and a readmission date of 4/02/09 with diagnoses of Chronic Obstructive Pulmonary Disease, Dementia, Bilateral Pneumonia, and Lung Mass. Review of the physician's orders dated 3/11/11 documented, &quot;...O2 @ 2L/M [minute] via N/C.&quot;</td>
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<td>Observations in the 100 hall on 3/16/11 at 1:30 PM, revealed RR #3 seated in a wheelchair with O2 binalas cannula tubing connected to an empty portable O2 tank.</td>
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<td>F 332</td>
<td>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</td>
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<td>4/8/11</td>
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<tr>
<td>SS=0</td>
<td>The facility must ensure that it is free of medication error rates of five percent or greater.</td>
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<td>This REQUIREMENT is not met as evidenced</td>
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Continued From page 16

by:

Based on policy review, medical record review, observation, and interview, it was determined the facility failed to ensure 3 of 8 [Nurses # 2, 4, and 5] medication nurses administered medications with a medication error rate of less than 5 percent (%). Five medications errors were made out of 41 opportunities for error, which resulted in a medication error rate of 12.195%.

The findings included:


Observations in Resident # 5's room on 3/14/11 at 5:03 PM, Nurse # 4 administered crushed medications per tube. After administration of the medications a moderate amount of residue was left in the medication cups. Nurse # 5's failure to not administer all of the Xanax or Calcium with Vit D which resulted in medication errors # 1 and # 2.

During an interview in the conference room on 3/15/11 at 5:15 PM, the Director of Nursing verified there was residue left in each of the medication cups.

2. Review of the "Nasal Spray Administration Procedure for Adults" provided by the American
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(1) PROVIDER/SUPPLIER/CJA IDENTIFICATION NUMBER:</th>
<th>(2) MULTIPLE CONSTRUCTION</th>
<th>(3) DATE SURVEY COMPLETED</th>
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<tbody>
<tr>
<td>445453</td>
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<td>03/16/2011</td>
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**NAME OF PROVIDER OR SUPPLIER**

GRACE HEALTHCARE OF CLARKSVILLE

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

111 USSERY ROAD
CLARKSVILLE, TN 37043

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<tr>
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<th>COMPLETION DATE</th>
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<tr>
<td>F 332</td>
<td></td>
<td><strong>Continued From page 17</strong></td>
<td>F 332</td>
<td></td>
<td>Team, Maintenance Department, Environmental Services, Medical Records, Rehabilitation Department, Activities, and Medical Director.</td>
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<td>Society of Consultant Pharmacists documented, &quot;...have the patient gently blow their nose to remove excess mucous before administering the nasal spray...&quot;</td>
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<td>Medical record review for Resident #17 documented an admission date of 2/8/08 with diagnoses of Chronic Airway Obstruction, Morbid Obesity, Diabetes Mellitus II, Anxiety, and Non-dominant Side Hemiplegia. Review of a physician's order dated 3/1/11 documented, &quot;...FLONASE 0.05% NASAL SPRAY... INHALE 2 [two] SPRAYS IN EACH NOSTRIL DAILY...&quot;</td>
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<td>Observations in Resident #17's room on 3/15/11 at 9:05 AM revealed Resident #17 in bed. Nurse #2 entered the room to administer medications. Nurse #2 instilled 2 sprays of Flonase into Resident #17's left nare and then instilled 2 sprays of Flonase into the right nare. Nurse #2 did not instruct Resident #17 to blow her nose before the medication was administered, which resulted in medication error #3.</td>
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<td>During an interview outside room 402 on 3/15/11 at 9:17 AM, Nurse #2 stated, &quot;I should have had her [Resident #17] to blow her nose. The spray works better when you do that...&quot;</td>
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<td>3. Review of the facility's aerosol administration policy documented, &quot;...PROCEDURE... 9. The aerosol should be nebulized until all of the medication is gone...&quot;</td>
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<td>Medical record review for RR #2 documented an admission date of 1/20/11 with diagnoses of Cerebrovascular Accident, Tracheostomy, Gastrostomy, Aphasia, Dysphagia, and Acute and Chronic Respiratory Failure. Review of a</td>
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Continued From page 18

physician’s order dated 3/11/11 documented, "...Ipratropium Br [Bromide] 0.02% soln [solution] nebulizer treatment every 6 hours 7 AM, 1 PM, 7 PM, 1 AM... Albuterol 0.83% mg [milligrams] / [per] ml [milliliter] solu nebulize tx [treatment]; every 6 hours 7 AM, 1 PM, 7 PM, 1 AM..."

Observations in RR #2’s room on 3/15/11 beginning at 7:40 AM, Nurse #6 administered the nebulizer treatment. After 11 minutes, Nurse #5 disconnected the nebulizer and poured small amount of clear fluid that was left in the chamber into the garbage can. The nebulizer chamber having medication left in the chamber resulted in medication errors #4 and #5.

During an interview in the 100 hallway on 3/15/11 at 7:52 AM, Nurse #5 stated, "...usually have some [medication] left, may be a few drops, may be quite a bit, but [the treatment] went for 15 minutes..."

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

F 431
463.50(b), (d), (e) DRUG RECORDS,
LABEL/STORE DRUGS & BIOLOGICALS

F 431
4/8/11

Nurse #6 was in-serviced on 3/15/2011 by the Director of Nursing on proper storage of medications. Uncapped vial on insulin was disposed of. Treatment nurse was in-serviced on 3/15/2011 by Director of Nursing on locking of treatment cart.

All residents have the potential to be affected by this citation. An audit of medication carts was completed on 03/16/2010 by the Director of Nursing and/or Nursing Supervisor to ensure no insulin was stored in cart. An audit of treatment and medication carts was completed on 3/16/2011 to insure they were secure.
Continued From page 19

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:

Based on policy review, observation, and interview, it was determined the facility failed to ensure safe and secure storage of medications for 1 of 2 (treatment cart on the 400 hall) treatment carts and proper storage of insulin vials in 1 of 8 (500 hall) medication carts.

The findings included:

1. Review of the facility's medication storage policy documented, "...The facility shall store all drugs and biologicals in a safe, secure, and orderly manner... Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays and carts used to transport such items shall not be left unattended..."
Continued From page 20

Observations on the 400 hall on 3/14/11 at 11:28 AM, revealed an unlocked treatment cart.

During an interview on the 400 hall on 3/14/11 at 11:28 AM, Nurse #6 stated, "...[named treatment nurse] never leaves it unlocked... she's the one who checks everyone else to make sure the carts looked..."

2. Review of the facility's "Lilly Insulin Products Storage and Stability" policy documented; "...Not in-use (unopened) insulin products including vials, pens, and cartridges should be stored in a refrigerator... In-use insulin vials (opened) should be stored in a refrigerator..."

Observations at the 300 hall nurses' station on 3/16/11 at 2:25 PM, revealed eight opened vials of insulin and one unopened vial of insulin stored in the 300 hall medication cart. The insulin vials were not refrigerated.

During an interview at the 300 hall nurses' station on 3/16/11 at 2:25 PM, Nurse #6 was asked if the insulin vials were kept in the medication cart. Nurse #6 stated, "They [insulin vials] should be stored in the refrigerator after I used them this morning. I guess I forgot to put them back [in the refrigerator]."

During an interview in the conference room on 3/16/11 at 3:10 PM, the Director of Nursing confirmed the insulin vials should be stored in the refrigerator.

483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

The facility must establish and maintain an
Infection Control Program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
   The facility must establish an Infection Control Program under which it -
   (1) investigates, controls, and prevents infections in the facility;
   (2) decides what procedures, such as isolation, should be applied to an individual resident; and
   (3) maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
   (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
   (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
   (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
   Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

- Based on policy review, observations, and
Continued from page 22

Interview, it was determined the facility failed to ensure 1 of 5 nurses (Nurse #3) disposed of sharps properly into a designated container.

The findings included:

Review of the facility's "Sharps Disposal" policy documented, "...1. Whoever uses contaminated sharps will discard them immediately or as soon as feasible into designated containers... 2. Contaminated sharps will be discarded into containers that are... b. Puncture resistant... e. Impermeable and capable of maintaining impermeability through final waste disposal."

Observations in 300 hall on 3/15/11 at 8:26 AM, Nurse #3 discarded scissors from a suture removal kit in a red bag in Random Resident (RR) #4's room and disposed of the red bag in the 300 hall biohazard room in a red bin.

Observations in 100 hall on 3/15/11 at 10:22 AM, Nurse #3 discarded scissors from a suture removal kit in a red bag in RR #5's room and disposed of the red bag in the 100 hall biohazard room in a red bin.

During an interview in the conference room on 3/15/11 at 5:25 PM, the Director of Nursing (DON) was asked how she would expect sharps to be disposed of. The DON stated, "...expect to go in sharps [container]."

During an interview at the 300/400 hall nurses' station on 3/16/11 at 8:45 AM, Nurse #3 confirmed she did not dispose of the scissors in a sharps container.

F 465

483.70(h)

SAFE/FUNCTIONAL/SANITARY/COMFORTABLE
<table>
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<th>COMPLETION DATE</th>
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<tr>
<td>F465</td>
<td>E ENVIRON</td>
<td>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.</td>
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<td>E ENVIRON</td>
<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on review of the daily hot water temperature checks, observations and interviews, it was determined the facility failed to ensure a comfortable environment for residents during showers as evidenced by cool water temperatures in 3 of 3 (100, 200, and 400 halls) shower rooms. The hot water temperature on 3 of 3 halls (100, 200 and 300 halls) were also cold.</td>
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<td>The findings included:</td>
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<td>1. Review of the daily hot water temperature checks documented, water temperature ranges in the shower rooms of 96 degrees Fahrenheit (F) to 120.5 degrees F from 1/10/11 to 3/14/11.</td>
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<td>2. Observations in the 100 hall shower room on 3/15/11 at 7:45 AM, revealed the following hot water temperatures: a. Stall #1 - 96 degrees F. b. Stall #2 - 100 degrees F.</td>
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<td>Observations in the 100 hall shower room on 3/15/11 at 12:15 PM, revealed the following hot water temperatures: a. Stall #1 - 88 degrees F. b. Stall #2 - 90 degrees F.</td>
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<td>Observations in the 100 hall shower room on 3/16/11 at 8:05 AM, revealed the following hot water temperatures: a. Stall #1 - 95 degrees F. b. Stall #2 - 96 degrees F.</td>
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**F 465** Continued from page 24

Water temperatures:
- Stall #1 - 98.4 degrees F.
- Stall #2 - 104 degrees F.

Observations in the 100 hall shower room on 3/15/11 at 10:05 AM, revealed the following hot water temperatures:
- Stall #1 - 92 degrees F.
- Stall #2 - 98.6 degrees F.

3. Observations in the 200 hall shower room on 3/15/11 at 7:30 AM, revealed the following hot water temperatures:
- Stall #1 - 100 degrees F.
- Stall #2 - 100 degrees F.

Observations in the 200 hall shower room on 3/16/11 at 10:22 AM, revealed the following hot water temperatures:
- Stall #1 - 100 degrees F.

4. Observations in the 400 hall shower room on 3/15/11 at 8:10 AM, revealed the following hot water temperatures:
- Stall #1 - 100 degrees F.

Observations in the 400 hall shower room on 3/16/11 at 10:25 AM, revealed the following hot water temperatures:
- Stall #1 - 103.5 degrees F.
- Stall #2 - 104.5 degrees F.

5. Review of the daily hot water temperature checks documented water temperature ranges in resident rooms of 80.4 degrees F to 117.9 degrees F from 1/10/11 to 3/14/11.

6. Observations of the hot water temperatures on the 100 hall on 3/14/11 revealed the following:
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a. Room 100 - 98 degrees F at 10:40 AM and 100 degrees F at 5:15 PM.
b. Room 101 - 100 degrees F at 10:55 AM.
c. Room 109 - 90 degrees F at 11:00 AM.
d. Room 119 - 100 degrees F at 11:19 AM.
e. Room 115 - 100 degrees F at 11:22 AM.
f. Room 118 - 98 degrees F at 5:18 PM.
g. Room 110 - 100 degrees F at 5:20 PM.

Observations of the hot water temperatures on the 100 hall on 3/15/11 revealed the following:
a. Room 101 - 88 degrees F at 7:46 AM and 96 degrees F at 4:45 PM.
b. Room 115 - 100 degrees F at 7:50 AM.
c. Room 118 - 100 degrees F at 7:50 AM.
d. Room 112 - 100 degrees F at 4:50 PM.

Observations of the hot water temperatures on the 100 hall on 3/19/11 revealed the following:
a. Room 107 - 104.5 degrees F at 9:55 AM.
b. Room 100 - 105 degrees F at 9:55 AM.

7. Observations of the hot water temperatures on the 200 hall on 3/14/11 revealed the following:
a. Room 209 - 92 degrees F at 11:25 AM.
b. Room 207 - 88 degrees F at 11:30 AM.
c. Room 205 - 100 degrees F at 11:40 AM.

Observations of the hot water temperatures on the 200 hall on 3/15/11 revealed the following:
a. Room 200 - 90 degrees F at 10:40 AM and 4:45 PM.
b. Room 201 - 80 degrees F at 10:45 AM and 88 degrees F at 4:50 PM.
c. Room 209 - 88 degrees F at 10:33 AM and 82 degrees F at 4:55 PM.
d. Room 211 - 90 degrees F at 10:37 AM and 4:55 PM.
Observations of the hot water temperatures on the 200 hall on 3/16/11 revealed the following:
   a. Room 203 - 103.5 degrees F at 9:59 AM.
   b. Room 211 - 102 degrees F at 10:00 AM.

8. Observations of the hot water temperatures on the 300 hall on 3/14/11 revealed the following:
   a. Room 301 - 90 degrees F at 10:18 AM.
   b. Room 310 - 80 degrees F at 11:05 AM.
   c. Room 312 - 79 degrees F at 10:52 AM.
   d. Room 314 - 89 degrees F at 10:45 AM.
   e. Room 315 - 96 degrees F at 10:50 AM.
   f. Room 316 - 80 degrees F at 10:45 AM.

Observations of the hot water temperatures on the 300 hall on 3/15/11 revealed the following:
   a. Room 300 - 82 degrees F at 4:52 PM.
   b. Room 301 - 76 degrees F at 4:52 PM.
   c. Room 314 - 84 degrees F at 4:52 PM.
   d. Room 316 - 82 degrees F at 4:52 PM.

Observations of the hot water temperatures on the 300 hall on 3/16/11 revealed the following:
   a. Room 301 - 76 degrees F at 8:35 AM and 100 degrees F at 10:13 AM.
   b. Room 305 - 97.3 degrees F at 8:38 AM.
   c. Room 316 - 95.9 degrees F at 8:40 AM and 87.4 degrees F at 10:13 AM.

9. Observations of the hot water temperatures on the 400 hall on 3/14/11 revealed the following:
   a. Room 400 - 94 degrees F at 11:20 AM.
   b. Room 401 - 108 degrees F at 10:15 AM.
   c. Room 403 - 100 degrees F at 10:53 AM.
   d. Room 405 - 84 degrees F at 10:58 AM.
   e. Room 407 - 96 degrees F at 11:05 AM.
   f. Room 409 - 88 degrees F at 11:15 AM.

Observations of the hot water temperatures on
Continued From page 27
the 400 hall on 3/15/11 revealed the following:
  a. Room 401 - 92 degrees F at 4:55 PM.
  b. Room 405 - 86 degrees F at 4:51 PM.
  c. Room 410 - 102 degrees F at 4:59 PM.

10. During the group interview in the conference room on 3/14/11 at 2:30 PM, 9 of 9 alert and oriented residents complained of cold water temperatures.

During an interview in the Administrator's office on 3/15/11 at 5:00 PM, the Administrator was asked how long there had been problems with the hot water temperatures. The Administrator stated, "Just got a new system last week, fully operational tankless water system. Had an older boiler system... time to replace. Supposed to be continuous heat."

During an interview in the Administrator's office on 3/15/11 at 5:00 PM, the Maintenance Supervisor was asked about the tankless system. The Maintenance Supervisor stated, "...circulation problem, circulates [water] throughout the building. One of circulation pumps not working, been hearing from the residents today as well..."

During an interview in the 400 hall shower room on 3/16/11 at 7:50 AM, the Maintenance Supervisor stated, "One water heater igniter was malfunctioning so dumping cold water into hot..."

During the quality assurance (QA) interview in the Administrator's office on 3/16/11 at 2:40 PM, the Administrator was asked about problems the facility had identified. The Administrator stated cold water had been a concern of staff and residents since January (2011) and was discussed at the February 15th (2011) QA
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meeting. The old boiler wasn't reliable which is why new tankless system was put in March (2011).

F 497

483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE

The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.

This REQUIREMENT is not met as evidenced by:

Based on review of Certified Nursing Assistants (CNAs) in-service attendance records for 2010 and interview, it was determined the facility failed to ensure 5 of 30 (CNAs #2, 3, 4, 5, and 6) CNAs employed the entire year of 2010 received at least 12 hours (hrs) of in-service training for the year.

The findings included:

Review of the CNA in-service attendance records recorded the in-service hours for 2010 as follows:

a. CNA #2 with a hire date of 2/12/09 had 3 hrs.

b. CNA #3 with a hire date of 5/5/09 had 9 hrs.

F 497

4/8/11

1. Certified Nurse Assistant # 5, #2, #3 are no longer employed with the facility. Certified Nurse Assistants # 4 and #6 have been in service since the Assistant Director of Nursing and have not had the education requirement as of 3/29/11.

2. All Certified Nurse Assistants have the potential to be affected by this citation. An audit of in-service hours was completed by 3/29/2011.

3. The Assistant Director of Nursing and Human Resource Director were in-service on 3/25/2011 on providing and recording in-service hours by the administrator.

4. Audit of in-service hours will be completed 2 times a week times 1 month and 1 time a week times 2 months by the Director of Nursing and/or Administrator and/or until 100% compliance obtained. Results of audits will be reported to the Quality Assurance committee by the Director of Nursing X3 months or until 100% compliance obtained. Members of the Quality Assurance Committee are the Administrator, Medical Director, Director of Nursing, Social Services, Activities Director, Dietary Manager, Minimum Data Set RN, Medical Records, and Rehab Manager.
F 497

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d. CNA #5 with a hire date of 1/28/08 had 4 hrs.
e. CNA #6 with a hire date of 6/27/08, had 11.50 hrs.

During an interview in the conference room on
3/16/11 at 1:45 PM, the Assistant Director of
Nursing confirmed that these were all of the
in-service hrs for these CNAs.

F 502

483.75(j)(1) PROVIDE/OBTAIN LABORATORY
SVC-QUALITY/TIMELINESS

The facility must provide or obtain laboratory
services to meet the needs of its residents. The
facility is responsible for the quality and timeliness
of the services.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it
was determined the facility failed to ensure
laboratory (lab) services were completed as
ordered by a physician for 1 of 24 (Resident #2)
sampled residents.

The findings included:

Medical record review for Resident #2
documented and admission date of 5/1/06 with
diagnoses of Cerebral Palsy and Seizure
Disorder. Review of a physician's order dated
4/1/10 documented, "...LIPID PANEL EVERY 6
MONTHS, TEGERETOL EVERY 4 MONTHS,
APRIL, AUGUST, DECEMBER." The facility was
unable to provide documentation that the Lipid
panel and Tegretol level were obtained as
ordered.

During an interview at the 200 hall nurses' station
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on 3/15/11 at 10:00 AM, the Director of Nursing stated, "I can not find that anything was done about the missing labs."