<table>
<thead>
<tr>
<th>F 241</th>
<th>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>SS=D</td>
<td>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</td>
</tr>
</tbody>
</table>

This REQUIREMENT is not met as evidenced by:

Based on policy review, observation, and interview, it was determined the facility failed to ensure residents' dignity was maintained when 2 of 11 Certified Nursing Assistants (CNA #1 and #4) failed to knock on the resident's door or gain permission to enter the resident's room or stood over the resident while assisting the resident to eat lunch.

The findings included:

1. Review of the facility's "RESIDENT RIGHTS GUIDELINES" policy documented, "...if resident is in his/her room, knock on the door, wait for a response and identify yourself..."

a. Observations in room 506 on 3/29/11 at 12:50 PM, CNA #4 failed to knock on the resident's door before entry with the food tray, left the resident's room to get milk, returned to the resident's room, and again failed to knock on the resident's door before re-entry.

Observations in room 707 on 3/29/11 at 12:55 PM, CNA #4 failed to knock on the resident's door before entry with the food tray.

b. Observations in room 711 on 3/29/11 at 1:00 PM, CNA #1 failed to knock on the resident's door.
Identification of Other Residents Potentially Affected:

Resident residing in the facility and those requiring assistance with feeding in their rooms have the potential to be effected by the deficient practice.

Measures/Systemic Changes Implemented:

Facility has a protocol related to knocking on doors and feeding residents at eye level. CNA #4 was re-educated regarding the facility protocol.

Direct Care Staff were re-educated by the Director of Clinical Education, Assistant Director of Nursing and or the Director of Nursing regarding facility protocol related to knocking on resident doors to gain permission to enter and feed residents at eye level.

Monitoring Changes:

Department Heads including: Assistant Director of Nursing Service's, Director of Clinical Education, Director of Nursing Services, Social Service, Business Office Manager, Activities, Executive Director will monitor through the Non-clinical round process randomly throughout the day and at random meals compliance with this alleged deficient practice. Any negative observations will be identified immediately and re-education will be provided immediately to that employee. Monitoring will be conducted at least 5 times a week times 2 weeks, then weekly times 2 weeks then monthly times 3 months findings will be reported in morning standup meeting Mon – Fri. These findings will be presented in the monthly Quality Assurance Committee monthly x3 months.
<table>
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<tr>
<th>ID</th>
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<th>ID</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
</table>
| F 241 | Continued From page 1 before entry with the food tray. During an interview in the hallway outside the beauty shop on 3/30/11 at 12:55 PM, the Director of Nursing (DON) was asked what she expected of the staff when entering a resident's room, the DON stated, "...expect knock and acknowledgement prior to enter..."
2. Observations in room 702 on 3/29/11 at 1:05 PM, CNA #4 stood over the resident while assisting the resident to eat.
During an interview in the hallway outside the beauty shop on 3/30/11 at 12:55 PM, the DON was asked what she expected the position of the staff when assisting a resident with meals. The DON stated, "...staff are to feed residents at eye level, not stand over..."
| F 273 | 483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT | F 273 | SS-D | 483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT 04/22/11 |
| SS-D | A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)
This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it was determined the facility failed to conduct a comprehensive assessment within 14 days of admission for 1 of 25 (Resident #7) sampled residents.

The facility conducts comprehensive assessment of residents within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition.

Residents Affected/Potentially Affected by the Cited Deficient Practice:
A comprehensive MDS Assessment has been completed on Resident #7 on 03/30/11.

Identification of Other Residents Potentially Affected:
Newly admitted residents have the potential to be affected by the alleged cited deficient practice. A complete audit was conducted by the District Clinical Reimbursement Specialist on 03/28-30/11 to identify if other residents were affected by the alleged cited deficient practice.
### F 273
Continued From page 2

The findings included:

Medical record review for Resident #7 documented an admission date of 3/11/11 with diagnoses of Transverse Myelitis, Quadriplegia, Diabetes Type II, Chronic Ulcer, and Neurogenic Bladder. The facility was unable to provide a comprehensive Minimum Data Set (MDS) for Resident #7.

During an interview in the conference room on 3/29/11 at 2:45 PM, the Administrator reviewed the MDS in the computer and stated, "...everything is in the computer, only section "K" is completed. The other sections are not done."

During an interview in the MDS Coordinator's office on 3/30/11 at 12:50 PM, the MDS Coordinator was asked what was the timeframe to complete the comprehensive assessment after admission. The MDS Coordinator stated, "Fourteen days from admission. I'm working on his [Resident #7] now..."

### F 273 (cont.)
Measures/Systemic Changes Implemented:

Registered Nurse Assessment Coordinators (RNAC) were re-educated on the timely completion of assessments by the District Clinical Reimbursement Specialist (DCRS) on 03/29/11. The DCRS established a scheduler (calendar) for the RNAC's to assist in the organization and tracking of MDS completion. Additionally, the DCRS educated the Executive Director on how to review and monitor the calendar.

**Monitoring Changes:**

The Executive Director will monitor the calendar daily Mon–Fri in Morning Meeting to ensure completion dates and verify compliance. Audits will be conducted at least 5 times a week times 2 weeks, then weekly times 2 weeks then monthly times 3 months by the Executive Director to verify compliance.

Compliance of this system will be reviewed monthly times 3 months at the Quarterly Quality Assurance and Assessment Meeting as reported by the Executive Director. The Quality Assurance and Assessment Committee includes the Medical Director, Administrator, Director of Nursing Services and members of the Interdisciplinary Department Team. The Quality Assurance and Assessment Committee will evaluate the effectiveness of the plan and revise the plan including the development and implementation of additional strategies as necessary based on the outcomes achieved.
F 278 Continued From page 3
that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it was determined the facility failed to accurately complete the Minimum Data Set (MDS) to reflect urinary incontinence and speech clarity for 1 of 25 (Resident #14) sampled residents.

The findings included:
Medical record review for Resident #14 documented an admission date of 6/18/99 with diagnoses of Transient Cerebral Ischemia, Vascular Dementia, Psychosis, Anemia, Depressive Disorder, Osteoporosis, Convulsions, Anxiety, and Hypertension. Review of the full annual MDS assessment with an assessment reference date of 11/17/10 and the quarterly MDS assessment with an assessment reference date of 2/17/11 documented, Resident #14 had clear speech and was always continent. Review of the care plan dated 1/25/11 documented, "...I have a
Continued from page 4

communication board and staff is well adapted to meeting my needs as I have been in this facility since 1999..." Review of the "Resident Continence Log" for February, 2011 and March, 2011 documented the resident was incontinent.

During an interview in the Executive Director's office on 3/30/11 at 8:45 AM, Nurse #5 confirmed incontinence should have been on the MDS and stated, "I will have to modify it [MDS], she [Resident #14] does not speak, I have never heard her say anything. She does have a communication board, the staff understand her.

483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

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

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment, prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced
F 280 Continued From page 5

by:
Based on policy review, medical record review, observation and interview, it was determined the facility failed to revise or update the care plan to reflect the current status for hospice, range of motion, oxygen therapy, urinary tract infection (UTI), Foley catheter care and/or mechanical lift for transfers for 4 of 25 Residents (#6, 7, 11 and 19) sampled.

The findings included:

1. Medical record review for Resident #6 documented an admission date of 1/15/10 with diagnoses of Acute Kidney Failure, Chronic Airway Obstruction, Anxiety, Atrial Fibrillation, Unspecified Psychosis, Depressive Disorder and Vascular Dementia with Delusions. Resident #6’s care plan dated 1/13/11 did not include hospice care, range of motion or oxygen therapy.

During an interview in the West Wing nurse’s station on 3/30/11 at 1:03 PM, the Assistant Director of Nursing (ADON) confirmed, "...no care plans in chart for hospice, range of motion and oxygen therapy.'

2. Medical record review for Resident #7 documented an admission date of 3/11/11 with diagnoses of Quadriplegia, Transverse Myelitis, Hypertension, Depressive Disorder, Diabetes Mellitus Type II, Infectious Micro-organism Resistant, and Neurogenic Bladder. Review of a physician’s order dated 3/11/11 documented, "...F/C [Foley catheter] to bsb [bed side bag], change pm [as needed]..." Resident #7’s care plan dated 3/11/11 did not include Foley catheter or UTI as problems nor were there interventions for care related to these problems.

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
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<tbody>
<tr>
<td>F 280</td>
<td>Identification of Other Residents Potentially Affected:</td>
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<tr>
<td></td>
<td>Residents with: hospice, range of motion, oxygen therapy, urinary tract infection, Foley catheter care and mechanical lift for transfers have the ability to be affected by the alleged cited deficient practice. An audit has been completed by the RNAC’s, DNS, ADNS and SS to identify other residents who may have been affected. Any identified concerns have been corrected.</td>
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<td>Measures/Systemic Changes Implemented:</td>
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<tr>
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<td>During Morning Meeting team members will review physician orders that have occurred within the past 24 to 72 hours and interventions recommended by the IDT. During this review, care plans will be update by the team. Morning Meeting occurs Mon – Fri.</td>
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<td></td>
<td>Monitoring Changes:</td>
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<td></td>
<td>Care Plans will be audited 5 times weekly for accuracy by the IDT Team. Results of the audit will be reviewed monthly times 3 months at the Monthly Quality Assurance and Assessment Meeting as reported by the Director of Nursing Services. The Quality Assurance and Assessment Committee includes: the Medical Director, Administrator, Director of Nursing Services and members of the Interdisciplinary Department Team. The Quality Assurance and Assessment Committee will evaluate the effectiveness of the plan and revise the plan including the development and implementation of additional strategies as necessary based on the outcomes achieved.</td>
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</table>
During an interview at the East Wing nurse's station on 3/30/11 at 6:10 AM, Nurse #4 and Nurse #5 were asked if a resident with a Foley catheter and a UTI should have a care plan with these problems identified. Nurse #4 stated, "...absolutely, expect Foley and UTI to be on the care plan..." Nurse #5 stated, "...yes, expect the Foley and UTI to be care planned... and it is not..."

3. Medical record review for Resident #11 documented an admission date of 8/20/04 with diagnoses of Mental Retardation, Infantile Cerebral Palsy, Obesity, Paraplegia, Diabetes Type II, and Osteoporosis. Review of the comprehensive care plan reviewed on 3/15/11 documented, "...Impaired physical mobility related to: dx [diagnosis] of Cerebral Palsy... assist in ADL's [activities of daily living] and mobility as needed..." Review of the "MDS [Minimum Data Set] Kardex Report" sheet dated 2/1/11 documented, "...Transfer: TOTAL DEPENDENCE Two person physical assist..." The care plan dated 3/19/11 did not include an intervention for the use of a mechanical lift for all transfers.

Observations in Resident #11's room on 3/28/11 at 2:07 PM, revealed Resident #11 was transferred from his bed to a Broda chair by two Certified Nursing Assistants (CNA) with the use of a mechanical lift.

During an interview at the West Wing nurse's station on 3/29/11 at 3:20 PM, CNA #8 stated, "He [Resident #11] is always gotten up with the big mechanical lift;"

During an interview at the West Wing nurse's
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Golden LivingCenter - Springfield

**Street Address, City, State, Zip Code:** 104 Watson Road, Springfield, TN 37172

**Date Survey Completed:** 03/30/2011

#### (X4) ID PREFIX TAG (X5) ID PREFIX TAG

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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>
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<tbody>
<tr>
<td>F 280</td>
<td>Continued From page 7 station on 3/30/11 at 9:20 AM, Nurse #6 was asked how was Resident #11 transferred. Nurse #6 stated, &quot;Mechanical lift.&quot; Nurse #6 reviewed the care plan and stated, &quot;...[Mechanical lift] not on here, needs a better ADL care plan...&quot; 4. Medical record review for Resident #19 documented an admission date of 3/25/11 with diagnoses of Chronic Renal Failure, Congestive Heart Failure, Senile Dementia, Chronic Obstructive Pulmonary Disease, Hyperlipidemia, Unspecified Anemia, and Gout. Review of a physician's order dated 3/25/11 documented, &quot;...O2 [oxygen] @ [at] 2L [liters] / [per] NC[nasal cannula] PRN - Continuously Everyday...&quot; Review of Resident #19's care plan dated 3/27/11 did not have oxygen therapy listed as a problem nor were their interventions for oxygen therapy. During an interview at the West Wing nurse's station on 3/30/11 at 9:15 AM, the Assistant Director of Nurses (ADON) was asked if a resident with oxygen should have a care plan with this problem identified. The ADON stated, &quot;...yes, I expect her [Resident #19] to have a care plan concerning oxygen... no I don't see one for her...&quot;</td>
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<tr>
<td>F 315</td>
<td>F315 SS=D 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</td>
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<tr>
<td>483.25(d)</td>
<td>NO CATHETER, PREVENT UTI, RESTORE BLADDER</td>
<td>04/22/11</td>
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The facility offers catheter care per training and standards for CNA's.

Residents Affected/Potentially Affected by the Cited Deficient Practice:

Resident #19 was assessed for signs and symptoms of any ill effects such as infection or irritation related to the cited practice.
**Golden LivingCenter - Springfield**

**Identification of Other Residents Potentially Affected:**

Residents with foley catheters have the potential to be affected by the cited practice. Residents with foley catheters were assessed by a RN for symptoms of any ill effects such as infection or irritation.

**Measures/Systemic Changes Implemented:**

CNA #2 has been re-educated with return demonstration on proper foley catheter care, by DCE, ADNS or DNS. CNA’s have been re-educated on proper foley catheter care according to training and standards for CNA’s by the DCE, ADNS or DNS.

**Monitoring Changes:**

Observation of foley catheter care will be conducted at least 5 times a week times 2 weeks, then weekly times 2 weeks then monthly times 3 months by the DCS, ADNS, DNS and/or Licensed staff on random shifts. Results of random observations will be reported in the monthly Quality Assurance and Assessment Meeting as reported by the Director of Nursing Services X 3 months. The Quality Assurance and Assessment Committee includes: the Medical Director, Administrator, Director of Nursing Services and members of the Interdisciplinary Department Team. The Quality Assurance and Assessment Committee will evaluate the effectiveness of the plan and revise the plan including the development and implementation of additional strategies as necessary based on the outcomes achieved.
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<tr>
<td>F 315</td>
<td>Continued From page 9 3/30/11 at 9:50 AM, CNA #2 was asked how should catheter care be performed. CNA #2 stated, &quot;...I use alcohol prep to do catheter care...catheter care every shift means clean area every shift just like I did with the alcohol prep pad...&quot; During an interview in the conference room on 3/30/11 at 10:05 AM, DON was asked how should the staff perform catheter care. DON stated, &quot;...I expect catheter care with soap and water every shift and work inside to out...&quot; 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</td>
<td>F 315</td>
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<td>F 322</td>
<td>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, medical record review, observation, and interview, it was determined the facility failed to ensure staff provided care and services according to the facility's policy for Percutaneous Endoscopy Gastrostomy (PEG) tube for 1 of 2 Random Residents (RR #1) observed during medication administration. The findings included: Review of the facility's &quot;Medication Administration Enteral Tubes&quot; policy documented, &quot;...Aspirate</td>
<td>F 322 SS=D</td>
<td>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS 04/22/11</td>
<td>Facility personnel will administer medication according to enteral medication administration policy. Residents Affected/Potentially Affected by the Cited Deficient Practice: Random Resident #1 has been assessed for G-tube patency and abdominal assessment to include: bowel sounds and abdominal distention. Identification of Other Residents Potentially Affected: Resident receiving medication via G-tube have the potential to be effected by the alleged cited deficient practice. Assessment of other residents receiving medication via G-tube to include: bowel sounds and abdominal distention have been completed.</td>
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F 322 Continued From page 10

stomach contents with syringe. Check residual. Allow stomach contents to go back into stomach... Allow medication to flow down tube via gravity... Do not push medications through the tube..."

Medical record review for RR #1 documented an admission date of 3/18/11 with diagnoses of Cerebrovascular Disease, Chronic Kidney Disease, Hypertension, Hyperlipidemia, Esophageal Reflux, Diabetes, and Gastrostomy Status. Review of the physician's orders dated 3/21/11 documented "...AmLodipine Besylate 5 MG [milligrams] G [gastrostomy] Tube - two times a day... Metoprolol Tartrate 200 mg G Tube - two times a day... Docusate Sodium 15 ML [milliliters] G Tube - two times a day... Prostat Profile 30ml... per g-tube bid [two times a day]... May crush medications and administer per GT [gastrostomy tube]."

Observations in RR #1's room on 3/28/11 at 4:20 PM, Nurse #2 placed an empty syringe into RR #1's PEG tube, injected air into the tube, and auscultated the abdomen with a stethoscope. Nurse #2 pushed 60 ml of water into the tube. Nurse #2 pushed the crushed medications and Colace liquid that had been diluted with water into the tube. Nurse #2 pushed 60 ml of water into the tube. Nurse #2 did not check for residual and did not allow the medications or flushes to flow by gravity through the tubing.

During an interview on the 300 hall on 3/30/11 at 8:30 AM, Nurse #2 confirmed she did not allow the medications or the flushes to flow by gravity through the PEG tube. Nurse #2 stated, "...usually push medications and liquids through the PEG tube."

F 322 Measures/Systemic Changes Implemented:

Nurse #2 has been re-educated with return demonstration on proper treatment and services of a resident receiving medications via G-tube tube by DCE, ADNS or DNS.

Licensed nurses have been re-educated on proper treatment and services of residents receiving medications via G-tube by DCE, ADNS or DNS.

Monitoring Changes:

Observation of delivery of medications via G-tube will be conducted by the DCE, ADNS and DNS to identify any deficient practice. The observation will be weekly x 5 weeks on random shifts, then weekly x 1 for 2 months. Results of the observation will be reviewed monthly in the Quality Assurance and Assessment Meeting as reported by the Director of Nursing Services. The Quality Assurance and Assessment Committee includes: the Medical Director, Administrator, Director of Nursing Services and members of the interdisciplinary Department Team. The Quality Assurance and Assessment Committee will evaluate the effectiveness of the plan and revise the plan including the development and implementation of additional strategies as necessary based on the outcomes achieved.
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<tbody>
<tr>
<td>F 323 SS-D</td>
<td></td>
<td><strong>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</strong></td>
<td>F 323 SS-D</td>
<td></td>
<td><strong>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</strong></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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<td>This <strong>REQUIREMENT</strong> 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 the resident environment remained free of electrical hazards by storage of a hair blow dryer with the electrical cord plugged in over an eye wash station in 1 of 3 (West wing) resident shower rooms.</td>
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<td>The findings included:</td>
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<td>Observations of the West wing residents' shower room revealed the following:</td>
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<tr>
<td></td>
<td></td>
<td>a. On 3/28/11 at 4:40 PM, a hair blow dryer was on the counter and plugged in above the eye wash station.</td>
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<td>b. On 3/28/11 at 7:45 AM and on 3/30/11 at 9:00 AM, a hair blow dryer was on the counter and plugged in above the eye wash station with the electrical cord looped around the eye wash faucet.</td>
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<td>During an interview in the West wing shower room on 3/30/11 at 9:00 AM, Certified Nursing Assistant (CNA) #1 was asked if it [hair dryer plugged in and the electrical cord looped around the eye wash faucet] was acceptable. CNA #1</td>
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Facility promotes residents environment free of accident hazards. 

**Residents Affected/Potentially Affected by the Cited Deficient Practice:**

No residents were negatively affected by the cited deficient practice.

**Identification of Other Residents Potentially Affected:**

Resident utilizing hair dryer in West Wing shower room have the potential to be affected by the cited deficient practice. The hair dryer was placed in safe storage.

**Measures/Systemic Changes Implemented:**

West Wing staff were re-educated on the proper storage on hair blow dryer by the DCE, ADNS or DNS.

**Monitoring Changes:**

Department Heads including: ADNS, DNS, DCE, SS, BOM, ACT and ED will monitor through the Non-clinical round process randomly throughout the day for compliance with this alleged deficient practice. Any negative observations will be identified immediately and re-education will be provided immediately to that employee. Monitoring will be conducted at least 5 times a week times 2 weeks, then weekly times 2 weeks then monthly.
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENRERS FOR MEDICARE & MEDICAID SERVICES**

<table>
<thead>
<tr>
<th>Statement of Deficiencies and Plan of Correction</th>
<th>Provider/Supplier/Clinical Identification Number:</th>
<th>Date Survey Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>(X1) Provider/Supplier/Clinical Identification Number: 445137</td>
<td>(X2) Multiple Construction</td>
<td>03/30/2011</td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

GOLDEN LIVING CENTER - SPRINGFIELD

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Precised by Full Regulatory or LIC 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>Date of Completion</th>
</tr>
</thead>
</table>
| F 323 | Continued From page 12 confirmed "probably not..."  
During an interview in the conference room on 3/30/11 at 1:30 PM, the Administrator was asked for a policy on resident personal care item safety. The Administrator confirmed "...we do not have a policy [for safety of personal care equipment]..." | F 323 | times 3 months findings will be reported in morning standup meeting Mon - Fri. These findings will be presented in the monthly Quality Assurance Committee monthly x3 months. The Quality Assurance and Assessment Committee includes the Medical Director, Administrator, Director of Nursing Services and members of the Interdisciplinary Department Team. The Quality Assurance and Assessment Committee will evaluate the effectiveness of the plan and revise the plan including the development and implementation of additional strategies as necessary based on the outcomes achieved. | 04/22/11 |
| F 408 SS-D | 483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES  
If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident’s comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.  
This REQUIREMENT is not met as evidenced by:  
Based on medical record review and interview, it was determined the facility failed to provide the required services for specialized rehabilitation services for 1 of 8 (Resident #7) sampled residents receiving rehabilitation services.  
The findings included:  
Medical record review for Resident #7 documented an admission date of 3/11/11 with diagnoses of Quadriplegia, Transverse Myelitis, Hypertension, Depressive Disorder, Diabetes Mellitus Type II, and Neurogenic Bladder. Review of the physician's order dated 3/11/11 documented, "...Physical Therapy [PT] 6x [times] | F 408 | 483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES |  
The facility provides the required services for specialized rehabilitation services.  
**Residents Affected/Potentially Affected by the Cited Deficient Practice:**  
Resident #7 has evaluated by Physical Therapy and have been added to physical therapy case load.  
**Identification of Other Residents Potentially Affected:**  
Residents with orders for Physical Therapy have the potential to be affected by the cited deficient practice. An audit of residents with orders for Physical Therapy has been conducted by the DNS to determine that appropriate services have been provided. | 04/22/11 |
<table>
<thead>
<tr>
<th><strong>F 406</strong></th>
<th>Continued From page 13</th>
<th><strong>F 406</strong></th>
<th>Measures/Systemic Changes Implemented:</th>
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<td>[per] wk [week] x 30 days...&quot; The facility was unable to provide documentation of therapy visits after the evaluation on 3/11/11.</td>
<td></td>
<td>Education has been provided to the Physical Therapists and Rehabilitation Coordinator by the ED and therapy District Manager that all residents who have orders for therapy will receive treatment as ordered regardless of payer source or approval by the ED.</td>
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<td>During an interview at the rehabilitation department desk on 3/30/11 at 7:40 AM, the Rehabilitation (Rehab) Coordinator was asked why had Resident #7 not received PT 6xw/w x 30 days as ordered by the physician. The Rehab Coordinator stated, &quot;...he has been evaluated but not received any treatment due to no payer source and I have to get administration to sign off when there is no payer source... the administrator has been out of town for three weeks... he [Resident #7] has not received range of motion or anything.&quot; The Rehab Coordinator was asked if Resident #7's physician had been notified of the therapy being on hold. The Rehab coordinator stated, &quot;No, I have not notified the MD [Medical Doctor] of therapy being on hold.&quot;</td>
<td></td>
<td>Monitoring Changes:</td>
<td></td>
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<tr>
<td>F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</td>
<td></td>
<td>New therapy orders are reviewed in the Morning Meeting Mon - Fri and compared with the Rehabilitation Coordinator's case load for validation of services.</td>
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<td>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.</td>
<td></td>
<td>Compliance of this system will be reviewed monthly times 3 months at the Monthly Quality Assurance and Assessment Meeting as reported by the ED. The Quality Assurance and Assessment Committee includes: the Medical Director, Administrator, Director of Nursing Services and members of the Interdisciplinary Department Team. The Quality Assurance and Assessment Committee will evaluate the effectiveness of the plan and revise the plan including the development and implementation of additional strategies as necessary based on the outcomes achieved.</td>
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<td>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.</td>
<td></td>
<td>F 431 SS=D 483.60(b),(d),(e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS 04/22/11</td>
<td>The facility provides locked compartmentalized treatment carts.</td>
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Continued From page 14
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 observation and interview, it was determined the facility failed to ensure medications were stored in locked compartments in 1 of 10 (East wing treatment cart) medication storage areas.

The findings included:
Observations on the 600 hall on 3/28/11 at 11:10 AM, revealed the East wing treatment cart was left unlocked, unattended and out of the nurse's view.

During an interview on the 600 hall on 3/28/11 at 11:15 AM, the Director of Nursing confirmed the treatment cart should have been locked.

F 441
483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS
F 441 Continued From page 15

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

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

(b) Preventing Spread of Infection
1. When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
2. The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if 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:

F 441

F441 SS-15
483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

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

Residents Affected/Potentially Affected by the Cited Deficient Practice:
Residents in rooms: 101, 102, 103, 104, 107, 302, 303, 304, 305, 402, 403, 501, 606, 701 and 707 have been assessed for adverse reactions as they related to improper hand hygiene.

Identification of Other Residents Potentially Affected:
Residents residing in the facility have the potential to be affected by the cited deficient practice. Residents have been assessed for any signs and symptoms of infection related to the cited deficient practice. The assessments was completed by the DNS, ADNS, RN's and DCE.

Measures/Systemic Changes Implemented:
Nurse #1, #2, #3, and #4 along with CNA #1, #2, #3, #4, #5 #7 and #9 have been educated on proper hand hygiene and return demonstrated by DCE, ADNS or DNS.

Licensed nurses and CNA's have been re-educated on proper hand hygiene by the DCE, ADNS and DNS.
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/Clinic Identification Number:** 445137

**Multiple Construction:**
- **Building:**
- **Wing:**

**Date Survey Completed:** 03/30/2011

**Name of Provider or Supplier:** Golden LivingCenter - Springfield

**Street Address, City, State, ZIP Code:**
- 104 Watson Road
- Springfield, TN 37172

### Summary Statement of Deficiencies

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<tr>
<th>ID Prefix</th>
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Based on on policy review, observation and interview, it was determined the facility failed to ensure practices to prevent the potential spread of infection were maintained by 4 of 7 (Nurse #1, 2, 3 and 4) nurses observed administering medications and 7 of 11 Certified Nursing Assistants (CNAs #1, 2, 3, 4, 5, 7 and 9) failed to practice sanitary hand hygiene during dining observations.

The findings included:

1. Review of the facility's "Hand Washing" policy documented, "...Wash hands before and after resident contact. ...Use clean disposable hand towel to turn off faucet...."

2. Observations on the 100 hall on 3/28/11 at 3:55 PM, Nurse #1 entered room 101, answered and turned off the call light with her gloved hands. Nurse #1 removed the gloves, walked to the nurse's station and wheeled a resident to room 107. Nurse #1 applied gloves and administered an inhaler to the resident in room 107. Nurse #1 did not perform hand hygiene before administering an inhaler to a resident.

Observations in room 103 on 3/28/11 at 3:55 PM, Nurse #1 applied gloves, opened the medication cart and obtained eye drops (gtts). Nurse #1 administered the eye gtts to the resident in room 103. Nurse #1 did not perform hand hygiene prior to administering the eye gtts.

3. Observations in room 402 on 3/28/11 at 4:20 PM, Nurse #2 applied gloves, administered medications via the Percutaneous Endoscopy Gastrostomy (PEG) tube to the resident and removed her gloves. Nurse #2 did not perform...

### Provider's Plan of Correction

**ID Prefix** | **Tag** | **Description** |
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</table>

Hand washing observation will be conducted by the DCE, ADNS, DNS and RN's 5 times a week times 2 weeks, then weekly times 2 weeks then monthly times 3 months.

Compliance of this system will be reviewed monthly times 3 months at the Monthly Quality Assurance and Assessment Meeting as reported by the Director of Nursing Services. The Quality Assurance and Assessment Committee includes: the Medical Director, Administrator, Director of Nursing Services and members of the Interdisciplinary Department Team. The Quality Assurance and Assessment Committee will evaluate the effectiveness of the plan and revise the plan including the development and implementation of additional strategies as necessary based on the outcomes achieved.
F 441 Continued From page 17
hand hygiene after removing the gloves.

Observations in room 305 on 3/29/11 at 11:15
AM, Nurse #2 applied gloves, performed an
accuchek for the resident, removed the gloves,
applied new gloves, and cleansed the
 glucometer. Nurse #2 did not perform hand
 hygiene in between changing gloves.

During an interview on the 300 hall on 3/30/11 at
8:30 AM, Nurse #2 stated, "I know I should have
washed my hands more."

4. Observations in room 701 on 3/29/11 at 7:45
AM, Nurse #3 applied gloves, removed a
medication patch from the resident's left side of
chest and applied a new medication patch to the
right side of the resident's chest. Nurse #3
removed her gloves and assisted the resident in
re-positioning in bed. Nurse #3 applied gloves
and administered eye gts and oral medications
to the resident. Nurse #3 removed her gloves and
did not perform hand hygiene after changing
gloves or after direct resident contact.

5. Observations in room 605 on 3/29/11 at 12:10
PM, Nurse #4 applied gloves, performed an
accuchek for the resident, removed the gloves,
applied new gloves, and cleansed the
 glucometer. Nurse #4 removed the gloves,
applied new gloves, prepared an insulin injection
for the resident at the medication cart, then
administered the insulin to this resident, and
removed the gloves. Nurse #4 did not perform
hand hygiene when changing gloves.

6. Observations in room 302 on 3/29/11 at 7:20
AM, CNA #1 touched the bed control and
assisted the resident to position in bed. CNA #1
Continued from page 18

F 441 did not perform hand hygiene prior to meal tray preparation.

Observations in room 303 on 3/29/11 at 7:30 AM, CNA #1 touched the bed control and assisted the resident to re-position in bed. CNA #1 did not perform hand hygiene prior to meal tray preparation.

7. Observations in room 304 at 8:00 AM, CNA #2 moved the wheelchair and assisted the resident to re-position in bed. CNA #2 did not perform hand hygiene prior to meal tray preparation or prior to feeding the resident.

8. Observations in room 102 at 11:30 AM, CNA #3 moved the wheelchair and assisted the resident to re-position in bed. CNA #3 did not perform hand hygiene prior to meal tray preparation.

9. Observations in room 707 on 3/29/11 at 12:58 PM, CNA #4 touched the resident and did not perform hand hygiene prior to preparing the meal tray. CNA #4 served another meal tray to another resident without performing hand hygiene.

10. Observations in room 501 on 3/29/11 at 12:55 PM, CNA #5 washed her hands and turned the faucet off with her bare hands.

11. Observations in room 102 on 3/29/11 at 7:40 AM, CNA #7 served a meal to the resident, touched the resident to wake her, lowered the side rail, and adjusted the room air thermostat. CNA #7 then washed her hands, turned the water off with a paper towel and used the same paper towel to dry her hands. CNA #7 entered the hallway while continuing to dry her hands and
Continued from page 19

then placed the paper towel in her pocket. CNA
#7 repeated this same process in rooms 103 and
405.

12. Observations on the 500 hall at 3/29/11 at
6:05 AM, CNA #9 served the tray to the resident
and placed a towel on the resident’s chest. CNA
#9 did not perform hand hygiene before leaving
the room.

Observations on the 700 hall on 3/29/11 at 8:08
AM, CNA #9 re-positioned the resident up in the
bed, raised the head of the bed, placed a towel
on the resident’s chest, served the meal tray, and
took a wet wash cloth from the resident and
placed it on the sink. CNA #9 did not perform
hand hygiene prior to serving the meal tray or
prior to leaving the room.

13. During an interview in the Director of
Nursing’s (DON) office on 3/30/11 at 8:20 AM, the
DON was asked about hand hygiene in regard to
changing gloves. The DON stated, "Should
perform some type of hand hygiene in between
changing gloves."

During an interview in the DON’s office on 3/30/11
at 10:15 AM, the DON was asked about hand
hygiene in regard to touching equipment or
residents. The DON stated, "I would expect them
to use hand sanitizer or wash their hands if they
touch the resident or the environment."

During an interview in the hallway outside the
beauty shop on 3/30/11 at 1:00 PM, the DON was
asked how should the faucet be turned off after
hand washing. The DON stated, "Turn off faucet
using paper towel."