**STANDING STONE CARE AND REHAB**

**STREET ADDRESS, CITY, STATE, ZIP CODE**
410 W CRAWFORD AVENUE
MONTEREY, TN 38574

**NAME OF PROVIDER OR SUPPLIER**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

(X1) PROVIDER/SUPPLIER/Clinic Identification Number: 445363

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
C 03/05/2014

(F000) INITIAL COMMENTS

Complaint investigation #31571, #31668, #32232, #32280, #32389, and #33293, were completed on March 11, 2014, at Standing Stone Care and Rehabilitation. No deficiencies were cited related to complaint investigation #31571, #32232, #32280, and #33293. Deficiencies were cited related complaint investigation #31668 and #32389, under 42 CFR Part 483, Requirements for Long Term Care Facilities.

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

(F280) PROVIDER'S PLAN OF CORRECTION

Standing Stone Care and Rehabilitation does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care; contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Poor Review, Quality Assurance or self-critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.

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 by:

- Based on medical record review, review of

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE

**TITLE**

**DATE**

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 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 program participation.
In-services, observation, and interview, the facility failed to revise the Care Plan to include the correct technique to transfer for one resident (#3) of eleven residents reviewed.

The findings included:

Resident #3 was admitted to the facility on May 3, 2013, with diagnoses including End Stage Renal Disease, T-1 and T-6 Fractures, Dementia, Diabetes Mellitus, and Alzheimers Disease.

Medical record review of the 60 day Perspective Payment System (PSS) Minimum Data Set (MDS) dated January 25, 2014, revealed the resident was moderately impaired cognitively, required extensive assistance with all Activities of Daily Living (ADL), and required assistance of two for transfers and ambulation.

Review of a facility investigation dated August 14, 2013, revealed "...resident injured...fracture of unknown origin to rt (right) shoulder..."

Medical record review of the Care Plan dated November 21, 2013, revealed ". . .two person assist with transfers...rt arm sling in place until ortho visit...ext (extensive) assistance with walking...[no instructions not to use the arms for transfers]."

Review of In-Service Education Report dated August 16, 2013, revealed ". . .The importance of continuing to use correct technique to transfer...gait belt as needed..."

Observation on February 27, 2014, at 9:15 a.m., in the hall revealed the resident ambulating with one Physical Therapist, no right arm sling, and a
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<td>F-280</td>
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<td>Continued From page 2 gait belt in use. Interview with the Interim Director of Nursing (DON) on February 27, 2014, at 10:40 a.m. In the DON's office confirmed the facility had serviced the staff not to transfer residents by lifting under the arms. Continued interview confirmed the facility had failed to revise the Care Plan to reflect the resident's current status (no arm sling) and the proper transfer technique. C/O #33289</td>
<td>F-281</td>
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<td>4. Findings of the above stated audit will be discussed in the QAPI committee meeting monthly for 3 months for recommendations and further follow up as needed. QAPI members consist of but not limited to, Medical Director, Director of Nursing, Assistant Director of Nursing, Unit Manager, Social Services Director, Dietary Manager and Quality of Life Director.</td>
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**STREET ADDRESS, CITY, STATE, ZIP CODE**
419 W CRANDOW AVENUE
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**PROFESSIONAL STANDARDS**

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation, and interview, the facility failed to follow the physician's orders for oxygen for one resident (#3) of eleven residents reviewed.

The findings included:

Resident #3 was admitted to the facility on May 3, 2013, with diagnoses including End Stage Renal Disease, T-1 and T-6 Fractures, Dementia, Diabetes Mellitus, and Alzheimers Disease.

Medical record review of the Physician's Recapitulation Orders dated February 2014 revealed "...Oxygen at 2 liters per minute by nasal cannula..."
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| F 281 | Continued From page 3 | Medical record review of the Care Plan dated November 21, 2013, revealed "...Breathing Difficulty...Administer per physician orders...Oxygen..."

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Observation on February 27, 2014, at 9:12 a.m., revealed the resident ambulating with physical therapy with no oxygen in use.

Observation on February 27, 2014, at 10:15 a.m., in the hall revealed the resident sitting in a wheelchair with no oxygen in use.

Interview with Registered Nurse #1 on February 27, 2014, at 10:15 a.m., at the Station Two Nurse’s Station confirmed the resident had an order for oxygen at 2 liters per minute by nasal cannula. Continued interview confirmed the facility had failed to follow a Physician’s order for oxygen for the resident.

C/O #32389

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Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, review of in-services, observation, and interview the facility
### Summary

**F 309**

Continued From page 4

failed to arrange a Dermatologist appointment for one resident (#8) and failed to provide safe transfer instructions to all caregivers for one resident (#3) of eleven residents reviewed.

The findings included:

Resident #8 was admitted to the facility on April 19, 2013, with diagnoses including Heart Failure, Diabetes Mellitus, Depression, Atrial Fibrillation, and Contact Dermatitis.

Medical record review of a hospital Discharge Summary dated April 19, 2013, revealed:

"...Subacute severe contact dermatitis bilateral hand and lower extremity...instructions...dermatology in one week..."

Medical record review of hospital Discharge Physician Orders dated April 19, 2013, revealed

"...need to see Dermatologist in 2 wk (week)..."

Medical record review revealed no documentation the facility arranged a Dermatologist appointment.

Interview with the Interim Director of Nursing (DON) on March 5, 2014, at 9:50 a.m., in the DON's Office revealed resident #8 was admitted to the facility with contact dermatitis and an order for a follow-up appointment in one-to-two weeks with a Dermatologist. Continued interview revealed the facility had failed to arrange a Dermatologist appointment for the resident.

Resident #3 was admitted to the facility on May 3, 2013, with diagnoses including End Stage Renal Disease, T-1 and T-6 Fractures, Dementia, Diabetes Mellitus, and Alzheimers Disease.
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Review of an In-Service Education Report dated August 16, 2013, revealed "...The importance of continuing to use correct technique to transfer...gait belt as needed..."

Observation on February 27, 2014, at 10:25 a.m., in the resident's room with Licensed Practical Nurse (LPN) #1, revealed two ambulance attendants transferring the resident from a wheelchair to a stretcher by lifting the resident under the bilateral arms.

Interview with a Registered Physical Therapist on February 27, 2014, at 11:05 a.m., in the therapy department revealed residents should never be lifted under the arms.

Interview with LPN #1 (present during the transfer by the ambulance attendants) on February 27, 2014, at 10:27 a.m., in the hall revealed the facility had failed to inform the ambulance attendants on the proper transfer technique prior to the transfer.

C/O #31668
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