F 164

483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS

The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another health care institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to maintain privacy during the group meeting for 9 of 9 alert and oriented residents participating in the group meeting.

NHC Springfield will continue to provide arrangements for a private area for patients.

Corrective actions accomplished for residents found to have been affected by the allegedly deficient practice:

The nurse who interrupted the meeting immediately apologized to the residents in the meeting. The Director of Nursing (DON) instructed this nurse on 8/3/10 in regards to patient personal privacy.

How we have identified other residents having the potential to be affected by the same practice and what corrective action has been taken:

The Social Services Director asked a random sample of 6 residents on the resident council if they have been interrupted during any of their meetings.

The Recreation Director has asked the Resident Council President and received permission to schedule the Social Services Director or their designee to make a presentation in regards to their personal privacy rights, specifically to discuss their right to meet personally with privacy.

The measures we have put in place and systematic changes we have made to ensure that the practice does not recur:

Employees will be instructed by the Administrator or his designee by September 7, 2010 regarding patients right to personal privacy and confidentiality.

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 disclosed 60 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 disclosed 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.
The corrective actions will be monitored to ensure the practice will not recur:

Compliance will be monitored by the Social/Service Director through the QA process to assure residents have the right to privacy and confidentiality.

Compliance will be monitored monthly x3 and continue as directed by the QA committee.

Completion Date: August 20, 2010

NHC Springfield will continue to provide or arrange for services to be provided by qualified persons in accordance with each resident's written plan of care.

Corrective actions accomplished for residents found to have been affected by the allegedly deficient practice:

The DON reviewed resident #7's plan of care and clarified that the resident's incontinent episodes are recorded as care planned. The DON performed a physical assessment on 7/27/10 of patient #11 related to bowel movements and intervened per care plan.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/ENTITY IDENTIFICATION NUMBER

445088

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

A. BUILDING

B. WING

07/28/2010

NAME OF PROVIDER OR SUPPLIER

NHC HEALTHCARE, SPRINGFIELD

STREET ADDRESS, CITY, STATE, ZIP CODE

608 8TH AVE EAST

SPRINGFIELD, TN 37172

(X4) ID PREFIX TAG

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

(X5) COMPLETION DATE

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

F 282

Continued From page 2

incontinent of my bowel and bladder... Bowel & [and] Bladder program per Silvercare..." Review of the Silvercare consult dated 4/20/10 documented, "...Toileting plan... document # [number] of Incontinent episodes..." The facility was unable to provide documentation of Resident #7's Incontinent episodes as care planned.

During an interview in the conference room on 7/28/10 at 10:27 AM, the Director of Nursing (DON) stated, "...the number of Incontinent episodes was not documented because she [Resident #7] is totally Incontinent...

2. Medical record review for Resident #11 documented an admission date of 12/9/09 with diagnoses of Parkinson's Disease, Spinal Stenosis and Degeneration, Cervical Spondylosis, Dysphagia, Gastroesophageal Reflux Disease, Acrocoronary Bypass, Cerebrovascular Accident, Kidney Disease, Dementia, and Fracture of Left Femur. Review of the comprehensive care plan dated 7/13/10 documented, "...Record my bowel movement pattern daily..." The facility was unable to provide documentation of Resident #11's bowel movements as care planned.

During an interview in the conference room on 7/27/10 at 10:30 AM, the DON stated, "...We don't record it [bowel movements] daily. The CNAs [Certified Nursing Assistants] get an assessment from the nurse..."

F 286

483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS

A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record.

F 286

How we have identified other residents having the potential to be affected by the same practice and what corrective action has been taken:

The DON has reviewed all residents who have been identified per the Quality Indicator Report to be Incontinent. These residents plan of care have been reviewed by the DON and Nurse Unit Manager for appropriate interventions specifically addressing incontinence.

The Nurse Unit Manager has reviewed all residents plan of care for notes of "record my bowel movement pattern daily" and intervened.

The measures we have put in place and systematic changes we have made to ensure that the practice does not recur:

The Nurse Unit Manager and/or DON will oversee direct caregivers to document Incontinent episodes and bowel movement patterns as care planned.
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<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F282</td>
<td>Continued From page 2</td>
<td>Incontinence of my bowel and bladder... Bowel &amp; [and] Bladder program per Silvarec...” Review of the Silvarec consult dated 4/20/10 documented, &quot;...Tolting plan... document # [number] of incontinent episodes...&quot; The facility was unable to provide documentation of Resident #7's incontinent episodes as care planned.</td>
<td>The corrective actions will be monitored to ensure the practice will not recur: Compliance will be monitored by the DON through the QA process to assure residents' services are provided or arranged to be provided by qualified persons in accordance with each resident's plan of care related to incontinence and bowel movement patterns. Compliance will be monitored monthly x3, then quarterly and will continue as directed by the QA committee.</td>
<td>Completion Date: August 27, 2010</td>
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</tbody>
</table>

2. Medical record review for Resident #11 documented an admission date of 12/20/03 with diagnoses of Parkinson's Disease, Spinal Stenosis and Degeneration, Cervical Spondylosis, Dysphagia, Gastroesophageal Re reflux Disease, Aortocoronary Bypass, Cerebrovascular Accident, Kidney Disease, Dementia, and Fracture of Left Femur. Review of the comprehensive care plan dated 7/13/10 documented, "...Record my bowel movement pattern daily..." The facility was unable to provide documentation of Resident #11's bowel movements as care planned. 

During an interview in the conference room on 7/27/10 at 10:30 AM, the DON stated, "...We don't record [bowel movements] daily. The GNAs [Certified Nursing Assistants] get an assessment from the nurse...

F286 483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS

A facility must maintain all resident assessments completed within the previous 15 months in the resident's active chart.
This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it was determined the facility failed to maintain
resident assessments completed within the previous 15 months in the active record for 1 of
20 (Resident #9) sampled residents.

The findings included:

Medical record review for Resident #9 documented an admission date of 1/25/07 with
diagnoses of Pressure Ulcers, Diabetes Mellitus, Peripheral Vascular Disease, Osteoarthritis,
Fractured Right Hip, Heart Disease, Essential Hypertension, Peptic Ulcer, and Bell's Palsy.
Review of the Resident Assessment Instrument (RAI) dated 7/9/09 revealed a Minimum Data Set
(MDS) dated 7/9/09 completed for Significant Change and Medicare 6 day stay. There was no
Resident Assessment Protocol Summaries (RAPS) or Care Plan (CP) for the assessment
timeframe of 7/9/09.

During an interview in the conference room on
7/28/09 at 1:10 PM, the Director of Nursing
acknowledged that the RAPS and CP for the
7/9/09 MDS were not maintained on the active record.

Based on the resident's comprehensive assessment, the facility must ensure that a
resident who enters the facility without an indwelling catheter is not catheterized unless the
resident's clinical condition demonstrates that
**F 286** Continued From page 3

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

Based on medical record review and interview, it was determined the facility failed to maintain resident assessments completed within the previous 15 months in the active record for 1 of 20 (Resident #9) sampled residents.

The findings included:

Medical record review for Resident #9 documented an admission date of 1/28/07 with diagnoses of Pressure Ulcers, Diabetes Mellitus, Peripheral Vascular Disease, Osteoarthritis, Fractured Right Hip, Heart Disease, Essential Hypertension, Peptic Ulcer, and Bell's Palsy.

Review of the Resident Assessment Instrument (RAI) dated 7/8/09 revealed a Minimum Data Set (MDS) dated 7/8/09 completed for Significant Change and Medicare 5 day stay. There was no Resident Assessment Protocol Summaries (RAPS) or Care Plan (CP) for the assessment timeframe of 7/8/09.

During an interview in the conference room on 7/28/09 at 1:10 PM, the Director of Nursing acknowledged that the RAPS and CP for the 7/8/09 MDS were not maintained on the active record.

**F 315**

483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER.

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that

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<td><strong>The corrective actions will be monitored to ensure the practice will not recur:</strong></td>
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<tr>
<td>Compliance will be monitored by the HIM through the QA process to assure resident assessments completed within the previous 15 months are in the resident's active record. Compliance will be monitored monthly x3, then quarterly and will continue as directed by the QA committee.</td>
<td>Completion Date: August 27, 2010</td>
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER
NHC HEALTHCARE, SPRINGFIELD

STREET ADDRESS, CITY, STATE, ZIP CODE
608 8TH AVE EAST
SPRINGFIELD, TN 37172

F 315 Continued From page 4
Catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

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 that perineal care was performed according to policy and procedure for 1 of 2 (Resident #3) residents observed during perineal care.

The findings included:
Review of the facility's "Perineal Care" policy documented, "...If using no-rinse perineal cleanser,...Gently wipe clean with washcloth, using one area of washcloth for each cleansing stroke...."

Medical record review for Resident #3 documented an admission date of 9/21/09 with diagnoses of Alzheimer's, Dementia, Cerebral Vascular Accident, Adult Failure to Thrive, Contractures, Hemiplegia and Depressive Disorder. Resident #3's urine cultures collected on 6/13/10 and 7/12/10 documented Escherichia coli as the organism identified. Resident #3 was diagnosed with a Urinary Tract Infection on 6/16/10 and 7/14/10.

Observations in Resident #3's room on 7/27/10 at 11:28 AM, revealed Certified Nursing Assistant (CNA) #1 performed perineal care on Resident #3 using a spray foam cleanser and a washcloth.

Corrective actions accomplished for residents found to have been affected by the allegedly deficient practice:
Perineal care was performed on resident #3 per policy after the observation.

How we have identified other residents having the potential to be affected by the same practice and what corrective action has been taken:
C.N.A. #2 received inservice on 7/30/10 by the DON in regards to proper protocol for cleaning the Perineal care.

Upon observation by the DON of random C.N.A.'s technique during pericare no other residents were affected by the deficient practice.

The measures we have put in place and systematic changes we have made to ensure that the practice does not recur:
The DON or the Unit Manager inserviced C.N.A.'s regarding protocol of cleaning the perineal area.
**NAME OF PROVIDER OR SUPPLIER:**
NHC HEALTHCARE, SPRINGFIELD

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
608 6TH AVE EAST
SPRINGFIELD, TN 37172

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<td>F 315</td>
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<td>The corrective actions will be monitored to ensure the practice will not recur:</td>
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<td>Compliance will be monitored by the DON to monitor 10 random C.N.A.s every month for 3x months to ensure proper procedure technique of perineal care. Compliance will be monitored monthly x3 will continue as directed by the QA committee.</td>
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<td>Completion Date: August 27, 2010</td>
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**STATEMENT OF DEFICIENCIES**

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<td>Continued From page 4...catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal-bladder function as possible.</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on policy review, medical record review, observation, and interview, it was determined the facility failed to ensure that perineal care was performed according to policy and procedure for 1 of 2 (Resident #3) residents observed during perineal care.</td>
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<td>The findings included:</td>
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<td>Review of the facility's &quot;Perineal Care&quot; policy documented, &quot;...If using no-rinse perineal cleanser... Gently wipe clean with washcloth, using one area of washcloth for each cleansing stroke...&quot;</td>
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<td>Medical record review for Resident #3 documented an admission date of 9/21/09 with diagnoses of Alzheimer's, Dementia, Cerebral Vascular Accident, Adult Failure to Thrive, Contractures, Hemiplegia and Depressive Disorder. Resident #3's urine cultures collected on 6/13/10 and 7/12/10 documented Escherichia coli as the organism identified. Resident #3 was diagnosed with a Urinary Tract Infection on 6/16/10 and 7/14/10.</td>
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<td>Observations in Resident #3's room on 7/27/10 at 11:29 AM, revealed Certified Nursing Assistant (CNA) #1 performed perineal care on Resident #3 using a spray foam cleanser and a washcloth</td>
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER
NHC HEALTHCARE, SPRINGFIELD

STREET ADDRESS, CITY, STATE, ZIP CODE
668 6TH AVE EAST
SPRINGFIELD, TN  37172

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

ID:  F 315
TAG:  Continued From page 5

F 315

Continued From page 5
after an incontinent bowel movement, after
spraying the foam cleanser on the washcloth
CNA #1 cleansed Resident #3 from front to back
3 times using the same area of the washcloth.
CNA #1 did not use a different area of the
washcloth for each cleansing stroke per the
facility's policy."

During an interview in the conference room on
7/26/10 at 10:00 AM, the Director of Nursing
(DCN) stated "...She didn't use another area or
another washcloth? ...I will follow-up...

ID:  F 514
TAG:  483.75(1)(1) RES
RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

F 514

The facility must maintain clinical records on each
resident in accordance with accepted professional
standards and practices that are complete;
accurately documented; readily accessible; and
systematically organized.

The clinical record must contain sufficient
information to identify the resident; a record of the
resident's assessments; the plan of care and
services provided; the results of any
preadmission screening conducted by the State;
and progress notes.

This REQUIREMENT is not met as evidenced by;
Based on medical record review and interview, it
was determined the facility failed to maintain
medical records for incontinent episodes,
Resident Assessment Protocol Summaries (RAP)
and Care Plan (CP) or bowel movements for 3 of
20 (Residents #7, 9, and 11) sampled residents.

NHC Healthcare Springfield will continue to maintain clinical records on
each resident in accordance with
accepted professional standards and
practices, that are complete; accurately
documents; readily accessible; and
systematically organized.

'Corrective actions accomplished for
residents found to have been affected
by the allegedly deficient practice:

Physical assessment revealed no
signs or symptoms or urinary retention
of Resident #7.

The Health Information Director (HIM)
moved the RAP for resident #9 from
overflow to the active chart on 7/28/10.

Physical assessment of Resident #
11 indicated revealed no problems with
bowel patterns.
## Continued From page 6

The findings included:

1. Medical record review for Resident #7 documented an admission date of 10/16/09 with diagnoses of Dementia, Fractious Stress, Muscular Degeneration, Dysphagia, Migraine, Constipation, Shortness of Breath, and Edema. Review of the comprehensive care plan dated 11/3/09 and updated on 11/24/09 documented, "I am incontinent of my bowel and bladder... Bowel & [and] Bladder program per Silvercare..." Review of the Silvercare consult dated 4/20/10 documented, "...Toileting plan... document # [number] of Incontinent episodes..." Resident #7's medical record did not contain documentation of Resident #7's incontinent episodes.

   During an interview in the conference room on 7/28/10 at 10:27 AM, the Director of Nursing (DON) stated, "...the number of incontinent episodes was not documented because she [Resident #7] is totally incontinent..."

2. Medical record review for Resident #9 documented an admission date of 12/6/07 with diagnoses of Pressure Ulcers, Diabetes Mellitus, Peripheral Vascular Disease, Osteoarthritis, Fractured Right Hip, Heart Disease, Essential Hypertension, Peptic Ulcer, and Bell's Palsy. Review of the Resident Assessment Instrument (RAI) dated 7/9/09 revealed a Minimum Data Set (MDS) dated 7/9/09 completed for Significant Change and Medicare 5 day stay. Resident #9's medical record did not contain Resident Assessment Protocol Summaries (RAPS) or a Care Plan (CP) for the assessment timeframe of 7/9/09.

   During an interview in the conference room on
**F 514**: Continued From page 7

7/28/09 at 1:10 PM, the Director of Nursing acknowledged that the RAPS and CP for the 7/9/09 MDS were not maintained on the active record.

3. Medical record review for Resident #11 documented an admission date of 12/8/09 with diagnoses of Parkinson’s Disease, Spinal Stenosis and Degeneration, Cervical Spondylosis, Dysphagia, Gastroesophageal Reflux Disease, Aortoocoronary Bypass, Cerebrovascular Accident, Kidney Disease, Dementia, and Fracture of Left Femur. Review of the comprehensive care plan dated 7/13/10 documented, "Record my bowel movement pattern daily..." Resident #11’s medical record did not have documentation of Resident #11’s bowel movements.

During an interview in the conference room on 7/27/10 at 10:30 AM, the DON stated, "...We don’t record it [bowel movements] daily. The CNAs [Certified Nursing Assistants] get an assessment from the nurse..."

**F 514**

The corrective actions will be monitored to ensure the practice will not recur.

Compliance will be monitored by the HIM through the QA process to assure resident assessments completed within the previous 15 months are in the resident’s active record.

Compliance will be monitored by the Nurse Unit Manager during care plan review to ensure care plans are followed accordingly.

Compliance will be monitored monthly x3 will continue as directed by the QA committee.

Completion Date: August 27, 2010