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<td>F 278</td>
<td>SS=d</td>
<td>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</td>
<td>F 278</td>
<td></td>
<td>NHC Springfield will continue to provide assessments to accurately reflect the patient’s status</td>
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The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

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

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation and interview, it was determined the facility failed to accurately complete the Minimum Data Set (MDS) to reflect the status of oxygen (O2) therapy, cognitive status and/or pressure ulcers.

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 patient. (See instructions.) Except for nursing homes, the findings stated above are disclosed 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 disclosed 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
The quarterly MDS with an ARD date of 9/18/11 was corrected by the director of social service on 11/3/11.

The social worker will review all Brief Interview for Mental Status (BIMS) forms in the patient record to ensure they accurately noted related to section C for cognitive patterns on the current MDS.

The MDS coordinator will inservice the social service director and admission coordinator who complete BIMS regarding section C for completeness and accuracy. This inservice will be completed by 11/11/11.

Compliance will be monitored by the MDS coordinator through the Quality Assurance process to assure accuracy of the MDS coding as it relates to the BIMS completed by the social service director. Compliance will be monitored monthly x3 and continue as directed by the QA committee comprised of the administrator, DON, physicians, and QA Coordinator and other staff as appropriate.
| Date (ARD) 6/18/2011, documented Resident #8 was assessed as able to complete the brief interview for mental status (BIMS) with a score of 15. The score range of 0 to 15 indicates no memory problems. Review of the quarterly MDS with an ARD of 9/18/2011, revealed section C for cognitive patterns, that Resident #8 was assessed as unable to complete the BIMS. The staff assessment for mental status was also not completed, but Resident #8 was assessed with "Modified Independence - some difficulty in new situations only" for cognitive skills for daily decision making.

During an interview at the east hall nurses' station on 10/25/2011 at 9:35 AM, the Social Worker (SW) was asked if Resident #8 had a change in cognitive status. The SW stated Resident #8 had no change in his cognitive status since admission and that he is alert, oriented and able to remember the memory words associated with the BIMS.

During an interview in the conference room on 10/25/11 at 2:45 PM, MDS Coordinator #1 confirmed Section C - Cognitive Status on the quarterly MDS dated 9/18/11 was not accurate.

During an interview in the conference room on 10/25/11 at 3:10 PM, the SW verified that section C - cognitive status on the quarterly MDS dated 9/18/2011 was not accurate and he had been unable to find additional information.

Review of the discharge assessment MDS with an ARD of 7/18/11, documented Resident #8 was assessed with Stage 2 pressure ulcer.

Review of the quarterly MDS with an ARD of

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Review of the discharge assessment MDS with an ARD of 7/18/11, documented Resident #8 was assessed with Stage 2 pressure ulcer.

Review of the quarterly MDS with an ARD of
F 278 Continued From page 3
9/18/11 documented in Section M 0900 that Resident #8 had no "pressure ulcers present on the prior assessment (OBRA [Omnibus Budget Reconciliation Act], PPS [Prospective Payment System], or Discharge]." This assessment failed to document the presence of the pressure ulcer that was present on the prior assessment of 7/18/11.

During an interview in the conference room on 10/25/11 at 2:24 PM, MDS Coordinator #1 verified the MDS assessment previous to the quarterly assessment of 9/18/11 was the discharge assessment of 7/18/11, and that Resident #8 had no other assessments between these two assessments. Resident #8 was transferred to the hospital on 7/18/11, but had no significant change and was not Medicare skilled upon return to the facility; therefore, an assessment was not completed until the next scheduled quarterly assessment on 9/18/11.

During an interview in the conference room on 10/25/11 at 2:30 PM, the Wound Care Nurse (WCN) stated she was responsible for completion of Section M - Skin Conditions on the MDS. The Wound Care Nurse verified Resident #8 had a Stage 2 pressure ulcer when transferred to the hospital 7/18/11, which was documented on the discharge assessment. The WCN verified the quarterly MDS dated 9/18/11 documented "...no pressure ulcers were present on the prior assessment."

F 315 483.25(d) NO CATHETER, PREVENT UTI, SS=0. RESTORE BLADDER

Based on the resident's comprehensive assessment, the facility must ensure that a
F 315 Continued From page 4
resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that 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 medical record review, observation and interview, it was determined the facility failed to ensure there was a physician's order to change a foley catheter and failed to ensure the correct size foley was used on 1 of 2 (Resident #5) sampled residents with foley catheters.

The findings included:
Medical record review for Resident #5 documented an admission date of 8/1/11 with diagnoses of Diabetes Mellitus, Depression and Urinary Retention. Review of the physician's order dated 8/3/11 documented, "...18 FR [French] [with] 10CC [cubic centimeters] FOLEY CATH [catheter] TO BSB [bedside bag] FOR URINARY RETENTION..." Review of Resident #3's nurse's notes dated 8/8/11 at 4:45 PM documented, "...Urinary catheter came out... replaced c [with] 18 FR [French] catheter..." There was no order documented to change the foley catheter.

Review of Resident #3's nurse's notes Resident #3 dated 9/29/11 at 1:00 AM documented, "...16 FR foley catheter was inserted..." The physician's order was not followed related to the size of the...
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER NUMBER**

NHC HEALTHCARE, SPRINGFIELD

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

605 8TH AVE EAST

SPRINGFIELD, TN 37172

**ID PREMI TAG** | **SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)** | **ID PREMI TAG** | **PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)**
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**F 315** Continued From page 5 catheter and there was no order to change the catheter.

Observations in Resident #5's room on 10/24/11 at 11:25 AM and 4:05 PM, revealed Resident #3's catheter bag was hanging on the left side of the bed in a black bag.

During an interview in the facility rehabilitation coordinator's office on 10/26/11 at 9:15 AM, the Director of Nursing confirmed there should be an order to change the Foley catheter and the correct size and bulb should be used.

**F 333** 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS

The facility must ensure that residents are free of any significant medication errors.

This REQUIREMENT is not met as evidenced by:

Based on review of the "GERIATRIC MEDICATION HANDBOOK" provided by the American Society of Consultant Pharmacists, review of the facility's "HIGHLIGHTS OF PRESCRIBING INFORMATION", observation and interview, it was determined the facility failed to ensure 1 of 7 (Nurse #1) nurses administered medications without a significant medication error. Nurse #1 failed to administer insulin within the proper time frame related to meals for Random Resident (RR) #1.

The findings included:

Review of the "GERIATRIC MEDICATION HANDBOOK" provided by the American Society

Compliance will be monitored by the Director of Nursing or the nurse unit manager through the Quality Assurance process to assure compliance with following physician's orders regarding indwelling catheterization and following policy and procedure related to urinary catheterization. Compliance will be monitored monthly x3 and continue as directed by the QA committee which is comprised of the administrator, DON, physicians, and QA coordinator and other staff as appropriate.

**F 333** Completion Date: 11/21/11

F333 NHC will continue to ensure that patients are free of any significant medication errors.

An Alert page placed on the front of Diabetic Monitoring Log of each patient receiving Humalog insulin to give meal/nutritional supplement to patient within time frame specified by the "Geriatric Medication Handbook".

Nurse #1 was inserviced on 10/28/11 by the DON on administering rapid-acting insulin (Humalog) within the proper time frame related to meals.

The DON and nurse unit managers reviewed the MARs on each nursing unit to identify patients with orders for administration of rapid-acting insulin (humalog) on 10/26/11.
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDERS/SUPPLIERS/CILA IDENTIFICATION NUMBER:** 445088

**(X2) MULTIPLE CONSTRUCTION**

A. BUILDING
B. WING

**(X3) DATE SURVEY COMPLETED:** 10/26/2011

**NAME OF PROVIDER OR SUPPLIER:** NHC HEALTHCARE, SPRINGFIELD

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 500 6TH AVE EAST SPRINGFIELD, TN 37172

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<td>The DON in-serviced licensed nurses on 11/14/11 regarding administration of rapid-acting insulin (Humalog) within the proper time frame related to meals. Alert drug stickers will be placed on the diabetic monitoring log for all patients receiving rapid-acting insulin (Humalog, Novolog, and Apidra) by 11/23/11. Alert stickers will indicate the need to administer insulin within time frame specified in the &quot;Geriatric Medication Handbook&quot; in regards to meals. The DON, nurse unit managers, and clinical pharmacist will conduct random observational audits of rapid-acting insulin (Humalog) administration within the proper time frame related to meals. Compliance will be monitored by the Director of Nursing or the nurse unit manager through the Quality Assurance process to ensure patients are free of any significant medication errors, specifically related to administration of rapid-acting insulin (Humalog) within the proper time frame related to meals. Compliance will be monitored monthly x3 and continue as directed by the QA committee comprised of the administrator, DON, physician, and QA Coordinator.</td>
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**F 514 | 483.75 H(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE**

**FORM CMS-2567(02-08) Previous Versions Obsolete**

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Facility ID: TN7403  
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| F 514 | NHC will continue to maintain clinical records on each patient in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible; and systematically organized. An Alert tab has been placed on MAR for all tube feeding flow records to ensure accuracy and completeness. This alert was placed on the MAR on 10/26/11. | | |
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F 514  Continued From page 7

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 ensure medical records were complete for 2 of 21 ( Residents #8 and 19) sampled residents.

The findings included:

1. Medical record review for Resident #8 documented an admission date of 3/1/11 with diagnoses of Insulin Dependent Diabetes Mellitus, Hypertension, Aortocoronary Bypass, Gastrostomy, Anxiety Disorder, Cerebral Vascular Accident and Hyperlipidemia. Review of the "Tube Feeding Records" dated September 2011 and October 2011 documented an order to "...FLUSH TUBE Q [every] 6 HRS [hours] WITH 200 CC [cubic centimeters] OF WATER ..."

There was incomplete documentation of the water flushes on 30 of 30 days for September 2011 and 25 of 25 days for October 2011.

During an interview at the east hall nurses station

F 614

The nurses who provided care for patient #8 will be in-serviced by 11/14/11 regarding completion and accuracy of the tube feeding flow record.

The licensed nurse responsible for obtaining the physician order to release the body to the funeral home of patient #19 will be in-serviced by 11/14/11.

The DON and nurse unit managers have reviewed the tube feeding records for all patients who receive tube feeding to ensure records are accurate and complete.

The nurse unit manager will audit the medical record by 11/14/11 for all expired patients since 10/1/11 to ensure physician orders to release the body were obtained.

The DON to in-service all licensed nurses by 11/14/11 regarding completion and accuracy of the tube feeding flow record every shift and obtaining physician orders to release the body to the funeral home.

Alerts have been placed on MARs for all tube feeding flow records to ensure the accuracy and completion of documentation on every shift.
**F 514** Continued From page 8 on 10/26/11 at 2:46 PM, while reviewing the "Tube Feeding Records" the Director of Nursing (DON) stated, it was expected the amount of water flushes administered to be documented each shift and totaled at 6 PM daily. The DON confirmed the records were incomplete.

2. Medical record review for Resident #19 documented an admission date of 11/01/10 with diagnoses of Dementia, Contusion of Left Hip and Knee, Acute Kidney, Failure to Thrive, Osteoarthritis, Cardiomegaly and Coronary Atherosclerosis. Review of the medical record revealed "Date Death 10-1-11 Time of Death 819 [8:19] AM Date of Body Release 10-1-11 Time of Body Release 950 [9:50] AM... to be delivered to [Name of Funeral Home]..." There was no order to release the body.

During an interview in the health information management office on 10/26/11 at 11:18 AM, the Health Information Director was asked for the order to release the body signed by the physician. The Health Information Director stated, "We checked the computer. There's not one."

**F 514** Compliance will be monitored by the Director of Nursing or the nurse unit manager through the Quality Assurance process to assure compliance with maintaining clinical records, specifically tube feeding flow records and orders to release a body to the funeral home were obtained, are complete, accurately documented; readily accessible; and systematically organized. Compliance will be monitored monthly x3 and continue as directed by the QA committee comprised of the administrator, DON, physician, and QA coordinator.

Completion date: 11/14/11