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SS-D

483.25(h) FREE OF ACCIDENT
HAZARDS/SUPERVISION/DEVICES

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
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This REQUIREMENT is not met as evidenced
by:

Based on medical record review, facility
document review, and interview, the facility failed
to provide assistance to prevent a fall for one
(#10) of twenty-four resident records reviewed.

The findings included:

Resident #10 was admitted to the facility on May
8, 2008 with diagnoses including Chronic Alveol
Obstruction, Congestive Heart Failure, Late Effect
Cerebrovascular Disease, Aortic Valve Disorder,
Muscle Weakness, Alzheimer's Disease,
Depressive Disorder, Psychosis, and Senile
Dementia with Delusion.

Medical record review of the Minimum Data Set
dated April 26, 2010 revealed resident #10 had
short and long term memory impairment.
Mildly impaired decision making skills,
required extensive assistance with two plus
person physical assistance for transfers, and
extensive assistance with one person physical
assistance for ambulation.

Medical record review of the Fall Risk
Assessment dated April 20, 2010 and July 13,
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER
TENNESSEE VETERANS HOME

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

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2010 revealed the resident was at high risk for falls.

Medical record review of the care plan dated April 28, 2010 revealed a problem addressing the risk for falls with the intervention of "...Have walker with in easy reach for transfers and ambulation. Requires extensive assist x 2 (by two) with ambulation and transfers."

Review of the facility document, Nurse Aide Information Sheet, updated April 20, 2010 revealed the resident required "...transfer: gait belt...2 assist...stands with extensive assist..." Further review revealed "...ambulation: 2 assist...gait belt...RW (rolling walker)..."

Medical record review of the Post Fall Nursing Assessment/Progress Note dated July 13, 2010 at 7:30 a.m., revealed the "...Resident was being transferred from bed to chair, buckled (resident) knees then had to be lowered to floor by staff." Further review revealed the Certified Nurse Assistant (CNA) #1 and #2 were present during the event.

Interview with CNA #1 at the east nursing station on September 29, 2010 at 7:50 a.m., revealed CNA #1 was the only staff member assisting the resident during the transfer from the bed when the resident’s knees gave out and was lowered to the mat. Further interview revealed CNA #1 called for assistance and CNA #2 entered the room to assist followed later by Licensed Practical Nurse (LPN) #1. Further interview confirmed the resident required extensive assistance with two plus person assistance for transfers.

Interview with CNA #2 at the east nursing station

4. Corrective actions will be monitored to ensure the deficient practice will not recur. The Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Unit managers, and Designees will review and update as necessary the resident care cards on a weekly, and as necessary basis to ensure the care cards are consistent with care provider orders and resident care needs and preferences. A sample ten percent of the in house resident census will be audited on a weekly basis to ensure accuracy of the care cards and that the assigned nursing staff members are knowledgeable of the resident care card contents, needs, desires, and preferences. These audits will commence on October 15th and will continue to be completed every week for 4 consecutive weeks, then monthly for 3 months, and reported to the Quality Assurance. Actions will be taken for any areas of noncompliance.
**Continued from page 2**

on September 29, 2010 at 7:50 a.m., confirmed CNA #2 was not present during the event. Further interview confirmed CNA #2 entered the room and saw the resident with their knees on the mat.

Interview, on September 29, 2010 at 8:20 a.m. In the Board Room, with the Regional Compliance Nurse confirmed the resident required extensive assistance with two person physical assistance with transfers and ambulation after reviewing the care plan and the Nurse Aide Information Sheet.