F 000. INITIAL COMMENTS

During annual recertification survey and complaint survey #28992 & #28877, conducted on March 26-28, 2012, at Sevier County Health Care Center, no deficiencies were cited in relation to the complaints under 42 CFR PART 482.13, Requirements for Long Term Care.

F 221. 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS

The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

This REQUIREMENT is not met as evidenced by:
Based on review of facility documentation, observation, and interview, the facility failed to assure restraints were properly applied for two residents, (#4, #8), of twenty-five residents reviewed.

The findings included:
Resident #4 was admitted to the facility on December 8, 2008, with diagnoses including Peripheral Neuropathy, Urinary Tract Infection, Congestive Heart Failure, Diabetes Mellitus and Osteoarthritis.

Medical record review of the Minimum Data Set (MDS), dated January 24, 2012, revealed the resident responded to simple and direct communication. Further MDS review revealed the resident required the use of bed rails on daily basis and no other restraints were required.

F 221. Restraint was immediately removed from Resident #4.

All residents with an order for a physical restraint has the potential to be affected.

CNA's will be given a daily care guide by their charge nurse.
Care guides will include restraints, ADL assistance and any new orders or changes.

Nursing Administration will do weekly restraint audits to ensure the correct restraints are applied to the correct resident per manufacturer's instructions. Audits will be done for a six (6) month period and any trends reported to the Quality Assurance committee.
F 221. Continued From page 1

Observation on March 27, 2012, at 11:00 a.m., in the resident’s room, revealed the resident sitting up in the wheelchair with a cushion slider belt in use (used to “assist a patient who slides down in the wheelchair and to remind a patient not to leave the wheelchair without assistance”). Continued observation revealed the resident was not aware of the device and could not remove the device upon request.

Observation and interview on March 27, 2012, at 11:15 a.m., in the resident’s room, with Licensed Practical Nurse (LPN) #2 and Certified Nurse Assistant (CNA) #1, confirmed the slider belt was in use for resident #4. Further interview confirmed the device was not indicated for resident #4 and was ordered for the resident’s roommate, resident #20. Continued interview confirmed the slider belt was placed on the wrong resident.

Review of the facility’s policy and procedure, Restraints (Physical), with no date, revealed “...notify Physical Therapy department of need for an evaluation for a physical restraint...notify physician of PT recommendation and obtain physician’s order...”

Interview with the Director of Nursing (DON), on March 27, 2012, at 1:06 p.m., in the DON office, confirmed the slider belt was a restraint, placed on the wrong resident and the facility failed to follow policy and procedure.

Resident #8 was admitted to the facility on September, 21, 2011, with diagnoses including, Vascular Dementia, Lumbar Stenosis, Depression, Alzheimer’s Disease, Obesity,
## DF 221: Continued From page 2

**Transient Ischemic Attack, and Hypertension.**

- Medical record review of the Minimum Data Set (MDS) dated, March 14, 2012, revealed the resident to be severely cognitively impaired, and dependent for all activities of daily living.

- Observation on March 26, 2012, at 10:08 A.M., in the resident's room, revealed the resident with a soft restraint belt positioned across the resident's torso just beneath the resident's armpits. Continued observation revealed the strap of the belt to be looped around the left rear portion of the wheelchair armrest and armrest support bar forming a knot, with the remaining portion of the strap extending across the rear of the wheelchair seat back and affixed to the other end of the belt with the female end of a quick release buckle. Continued observation revealed the right side strap of the restraint belt to be looped once around the base of the wheelchair arm rest support and then extending to the rear of the wheelchair seat back and affixed with the male end of the quick release buckle.

- Review of the facility documents “Quick-Release Cushion Belt” revealed, "...Place belt at patient's waist...Wrap the strap...secure...around the metal armrest bar just behind the armrest pad...repeat...see illustration A...Secure belt by inserting male end into female end...see illustration B."

- Interview with Licensed Practical Nurse #1, on March 26, 2012, at 10:15 A.M., in the resident's room, confirmed the restraint belt was not properly positioned across the resident's torso or properly secured to the chair per manufacturer's instructions.

**DF 221**

Soft belt restraint was immediately removed from Resident #8 and reapplied per manufacturer's instruction.

| Date: 03-30-12 |

All residents at Sevier County Health Care Center with physician orders for a physical restraint have the potential to be affected. All residents with restraints were observed by Nursing and Physical Therapy. No other trends observed.

- Physical therapy department will hold a restraint in-service on April 24, 2012 and April 25, 2012 for all nursing staff.

- Nursing Administration will do weekly restraint audits for a six (6) month period to ensure correct restraints on correct residents and all are applied per manufacturer's instructions. Any trends will be reported to the Quality Assurance committee.
F 221, Continued From page 3

specifications.

F 250 483.15(g)(1) PROVISION OF MEDICALLY
SS=D RELATED SOCIAL SERVICE

The facility must provide medically-related social
services to attain or maintain the highest
practicable physical, mental, and psychosocial
well-being of each resident.

This REQUIREMENT is not met as evidenced
by:

Based on medical record review, observation,
and interview, the facility failed to ensure
resident's needs were met by providing
appropriate social services for one resident (#19)
of twenty-five residents reviewed.

The findings included:

Resident #19 was admitted to the facility on
December 12, 2007, with diagnoses including
Hypertension, Congested Heart Failure, Diabetes,
and Atrial Fibrillation.

Review of the Minimum Data Set (MDS) dated
December 5, 2011, revealed the resident was
able to make self understood and was total
dependent for all activities of daily living.

Review of the care plan updated on December 5,
2011, revealed "resident stated misses long term
roommate who died suddenly four days ago."

Review of the social progress notes dated
December 8, 2011, revealed quarterly MDS
completed and care plan reviewed.

Social Services Director attempted
to counsel Resident #19. Resident
refused to discuss expired
roommate, requesting pain
medication. Senior counsellor
given referral 03-30-12

All residents in the facility
not in a private room have the
potential to be affected.

When resident expires at
facility or hospital, Social
Services director will go to
resident's room and talk to
roommate to assess if counselling
is needed or appropriate at that
time.

Follow-up visits with Resident
#19 will be made quarterly and
PRN.

Weekly audits will be done per
Nursing Administration to ensure
counselling is offered to any
resident who has lost a roommate
times six (6) months. Any
choices will be reported to the
Quality Assurance Committee.
F 250 Continued from page 4

Interview with the Social Worker on March 28, 2012, at 8:56 a.m., in the social worker's office, confirmed the social worker had not addressed the issue of the resident's roommate dying.

F 279: 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation, and interview, the facility failed to develop a care plan for one resident (#12) of twenty-five.

F 279: Dialysis access was immediately planned for Resident #12 and monitoring every shift was added to the TAR.

03-30-12

All dialysis residents at Sevier County Health Care Center have the potential to be affected. No other dialysis residents in facility.

Care plan nurses will be in-service related to dialysis residents.

04-16-12

Nursing Administration will do weekly audits to ensure dialysis access is care planned and being monitored per facility policy and procedure for six (6) months. Any trends will be reported to the Quality Assurance committee.
F 279: Continued From page 5 residents reviewed.

The findings included:

Resident #12 was readmitted to the facility on December 7, 2011, with diagnoses including Diabetes, Congestive Heart Disease, and End Stage Renal Disease.

Medical record review revealed the resident had a dialysis access (fistula) and received dialysis three days a week at an outpatient clinic.

Medical record review of the initial care plan dated September 15, 2011, revealed the care plan did not address the resident’s dialysis access (fistula) located in the upper right arm or the practice which requires no needle sticks or blood pressures in the arm of the access.

Observation on March 27, 2012, at 8:30 a.m., in the resident's room, revealed resident eating breakfast, stated was getting ready to leave for dialysis.

Interview with the Director of Nursing on March 27, 2012, at 1:45 p.m., in the Director of Nursing’s office, confirmed the care plan did not address the resident’s dialysis access.

F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

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

This REQUIREMENT is not met as evidenced
F 281: Continued From page 6

by:

Based on medical record review, observation, and interview, the facility failed to follow physician's orders for weight loss for one (#2) and failed to follow a physician's order for scheduling an appointment (#3) of twenty-five sampled residents.

The findings included:

- Resident #2 was admitted on January 16, 2012, with diagnoses including Senile Dementia, Anemia, Intertrochanteric Fracture.

Medical record review of the Minimum Data Set dated January 30, 2012, revealed the resident had moderately impaired cognitive skills and required assistance with all activities of daily living.

Medical record review revealed the resident's weight was one hundred and thirty-one pounds on admission. Medical record review of the Dietary Progress Notes dated January 25, 2012, revealed, "...feeds self with tray set-up...occasionally fed by staff when tires...Request Boost (supplement to increase calories and protein)." Further review revealed a speech therapy recommendation dated January 30, 2012, to place the resident on restorative dining.

Medical record review revealed the resident continued to lose weight dropping to one hundred and thirteen pounds on March 22, 2012.

Medical record of the Dietary Progress Notes dated March 7, 2012, revealed, "...resident stating

Resident #2 was given a spoon, Benecolore obtained and given to resident in her coffee and resident was supervised while finishing meals.

03-30-12

All Sevier County Health Care Center residents who require supervision with feeding have the potential to be affected.

All residents needing supervision with feeding were observed by Nursing to ensure help was being given and physician's orders were being followed.

All CNA's will be given a daily care guide by Charge Nurses before beginning each shift. Daily care guides will be updated weekly and PRN and will include those residents which require assist with feeding.

Weekly audits will be done by Wing supervisor to ensure all residents requiring assistance with meals are being assisted by staff at meal times. Also, to ensure ensure all appropriate residents attend the restorative dining program. These audits will be done for a six (6) month period. Any trends will be reported to the Quality Assurance
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>281</td>
<td>F</td>
<td>Continued From page 7 &lt;br&gt;not drinking Boost b/c (because) it is too sweet...will rec (recommend) d/c (discontinue) Boost and offer Benecal (supplement to increase calories) in coffee TID (three times daily).&quot;</td>
<td>281</td>
<td>F</td>
<td>Resident's doctor appointment had been made for May 01, 2012.</td>
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Medical record review of a physician's Assessment and Plan progress note dated March 9, 2012, revealed, "...weight loss - restorative dining...depression - start Remeron 7.5 mg, po (by mouth) at hs (bedtime) may help appetite too."

Observation on March 26, 2012, at 12:45 p.m., revealed the resident sitting in a small dining room (not the restorative dining room) picking at food receiving no assistance from staff.

Observation on March 27, 2012, at 8:00 a.m., revealed the resident sitting in the small dining room (not restorative dining room) not eating. When the resident was questioned as to why the resident was not eating, the reply was, "I don't have a spoon." Continued observation revealed when a spoon was obtained the resident did begin to eat. Further observation revealed Benecal was not placed in the resident's coffee.

Interview with CNA (certified nursing assistant) #2, on March 27, 2012, at 8:40 a.m., confirmed the resident had not been taken to the restorative dining room at breakfast, did not have the proper utensil to eat with and had not received the Benecal.

Observation on March 28, 2012, at 8:20 a.m., revealed the resident sitting in the resident's room, in a recliner, with the resident's breakfast tray in front of the resident. Observation revealed
Continued From page 8

the resident's Benecol had been placed in the resident's milk (not coffee) and the resident would not drink the milk.

Interview with CNA #3 on March 28, 2012, at 8:30 a.m., confirmed the CNA was unaware the Benecol was to be placed in the resident's coffee and was unaware the resident was to be in the restorative dining room.

Interview with the Skilled Unit Manager on March 28, 2012, at 9:30 a.m., confirmed the physician's orders for restorative dining and Benecol was not being followed. The resident's weight was obtained at that time with no further weight loss sustained.

Resident #3 was admitted to the facility on February 18, 2011, with diagnoses including Cerebral Arterial Occlusion, Hypertension, Muscle Weakness, Congestive Heart Failure, Diabetes Mellitus, Bilateral Amputation of Lower Extremities and Peripheral Vascular Disease.

Medical record review of the Minimum Data Set (MDS), dated March 26, 2012, revealed the resident was cognitively intact and required assistance with bathing, toileting and transfer.

Observation and interview with the resident at 10:45 a.m., in the resident's room, revealed the resident lying in the bed. Further interview revealed the resident requested the urologist appointment for March 2, 2012, be cancelled due to the distance and to make an appointment with an urologist closer to the facility.

Medical record review of a nurse's note, dated
F 281 Continued From page 9
March 2, 2012, revealed "cancelled appointment
with urologist, will call to reschedule".

Medical record review of a physician's order
sheet, dated March 9, 2012, revealed "
...reschedule appointment with local urologist for
recurrent Urinary Tract infection (UTI) problem ..."

Interview with Licensed Practical Nurse (LPN) #2,
on March 27, 2012, in the 100 Wing nurses
station, confirmed no documentation in the
medical record regarding the rescheduling of the
urology appointment.

Interview with the Unit Manager of the 100 Wing,
on March 28, 2012, at 9:30 a.m., in the nurses'
station, revealed the unit manager made the
appointment "approximately 1 week ago for May
1, 2012", had written the appointment date on a
note pad and locked it the drawer. Further
interview confirmed the manager had not told
anyone the appointment date and "was waiting on
family notification". Further interview confirmed
the facility failed to schedule the appointment for
the resident in a timely manner.

Interview with the Director of Nursing (DON), on
March 27, 2012, at 2:30 p.m., in the DON office,
confirmed the facility failed to schedule an
appointment for the resident in a timely manner.

F 371 483.35(i) FOOD PROCURE,
STORE/PREPARE/SERVE - SANITARY

The facility must -
(1) Procure food from sources approved or
considered satisfactory by Federal, State or local
authorities; and
(2) Store, prepare, distribute and serve food
**F 371** Continued From page 10
under sanitary conditions

This REQUIREMENT is not met as evidenced by:

Based on observation, review of facility documentation, and interview, the facility failed to document and maintain records for the monitoring of dish washing and rinsing machine temperatures.

The findings included:

Observation on March 27, 2012, at 8 a.m., in the kitchen, with the dietary manager, revealed the Dish Room Temperature and Product Record logs were incomplete. Further observation of a log with no date or month, (dietary manager stated "this was the month of December, 2011") revealed no documentation of temperature checks on the following dates: 9th, 21st, 27th, 25th, 30th. Further review of the logs revealed no documentation of temperature checks for the breakfast cycle on the following dates: 7th, 13th, 15th, 16th, 25th, 29th, 30th and 31st. Continued review revealed no documentation of temperature controls for the lunch and supper cycles on the following dates: 13th, 25th, 26th, 27th, and 29th.

Review of the facility policy, Dish Machine Temperature Log, revealed ...the food service director will provide the dishwashing staff with a log to be posted near the dish machine ...the food service director will train dishwashing staff to monitor dish machine temperatures throughout.

Corrective action to be taken for residents found affected by deficient procedure.

Identifying all residents who would have been affected by such procedure. Corrective action taken, more training and more closely monitoring situation.

Measures put in place to prevent reoccurrence. More training and monitoring by Dietary Manager by May 12, 2012.

Training to include importance of proper temperature and sanitation of dishes and making sure temps and cleaning schedules are documented.

Corrective actions to be taken would be yearly in-services for all employees and weekly monitoring of temperature logs by the Dietician and Dietary Manager so that this will not occur again.
F 371  Continued From page 11  
the dishwashing process...staff will be trained to  
record dish machine temperatures for the wash  
and rinse cycles at each meal...the food service  
director will spot check the log to assure  
temperatures are appropriate and staff is actually  
monitoring dish machine temperatures..."  

Interview with the Dietary Manager and Food  
Service Director, at 8:15 a.m., on March 27,  
2012, in the kitchen, confirmed the facility logs  
were incomplete and failed to follow the policy  
and procedure related to dish machine  
temperatures.