**F 225**

**SS=E**

<table>
<thead>
<tr>
<th>F 225</th>
<th>SS=E</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>483.13(c1)(ii)(iii), (c)(2) - (4)</strong></td>
<td><strong>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</strong></td>
</tr>
</tbody>
</table>

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

---

**LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

---

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 disclosable 50 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 continue program participation.
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 report an allegation of abuse and an injury of unknown origin to the state survey agency for 2 of 4 (Residents #244 and 254) incidents for residents included in the stage 2 review.

The findings included:

1. Review of the facility's abuse policy documented, "...Response at Completion of Investigation...Written notification to the State Health Department and other required regulatory agencies summarizing the incident, investigation results and facility actions...per the guidelines of individual state reporting requirements..."

2. Medical record review for Resident #244 documented an admission date of 5/6/12 with diagnosis of Late Effects of Cerebrovascular Accident, Diabetes Mellitus, Depression, Chronic Kidney Disease, Hemiplegia, Hypertension, Agitation, Constipation, Hypercholesterolemia and Pain. Review of the admission Minimum Data Set (MDS) dated 5/14/12 and the quarterly MDS dated 8/7/12 documented Resident #244's Brief Interview for Mental Status (SIMS) as 15, indicating no mental impairments. The quarterly MDS documented in Section E, "...Behavioral Symptoms - Rejection of Care Behavior occurred 1 to 3 days..."

Review of the care plan dated 8/21/12 documented, "...Inappropriate sexual advances..."
F 225 : Continued From page 2

toward staff... Refer to psych [psychiatric] services... Remind resident of inappropriate behavior and redirect as needed..."

Nurses notes dated 8/15/12 documented, "...resident noncompliant with smoking policy, found smoking on premises unsupervised. Reported to RP [responsible party] (sister) and she stated resident was manipulative and had been noncompliant with doctors orders and medications for a long time..."


During an interview in Resident #244's room on 10/2/12 at 5:22 PM, Resident #244 stated, "...I'm not treated right... I have told some things to the nurse and to the Administrator about things that were not right... The nurses and aids don't like it and now they ignore me. [Named certified nursing assistant (CNA) #8 and CNA #9]... the other night CNA #8 came in to change him [roommate] and when she was on the way out I told her I needed to be changed. She [CNA #8] said, '...It's a shame you lay up here and wet your bed. My little niece can change herself...' That hurts my feelings..."

Resident #244 was asked if this had been reported to the nurse or to the Administrator. Resident #244 stated, "...Did not report to nurse or [Administrator's first name]... want to report now..."

During an interview in the Administrator's office
F 225. Continued From page 3

on 10/3/12 at 9:00 AM, the Administrator was asked about the investigation concerning Resident #244. The Administrator stated, "...I have talked with the resident and was told of an allegation of an aide talking rude to him... The CNA [#8] was questioned and the roommate was questioned, both denied any incident as told by resident... resident has had inappropriate sexual comments and behaviors toward staff... Had problems in past with staff feeling uncomfortable in providing care... have moved the process from an allegation of abuse to the grievance process..."

During an interview in the Administrator's office on 10/3/12 at 4:52 PM, the Administrator was asked what was the facility's policy to report an allegation of abuse. The Administrator stated, "...Report to UIRS [unusual incident reporting system] within 24 hours if substantiated..." The Administrator was asked if he had reported the allegation made by Resident #244. The Administrator stated, "...I was going to, but after the review and comments from the staff... Based on the scheduling, assignments, his history, and statements the allegation was not substantiated... I wouldn't report it..."

During an interview in the Nurse Practitioner's office on 10/4/12 at 10:38 AM, the Director of Nursing (DON) was asked what allegations of abuse does the facility report. The DON stated, "...Allegations of abuse that are substantiated would be reported..."

The facility failed to report an allegation of abuse.

2. Medical record review for Resident #254
Continued From page 4
documented an admission date of 7/9/12 with
diagnoses of Dementia with Behavioral
Disturbances, Alzheimer's Disease, Muscle
Weakness, Hypertension, Anemia and Sente
Delusion. A physician's order dated 9/20/12
documented, "Send to ER [emergency room] for
Eval [evaluation] & [and] TX [treatment]."

Review of the "Resident Incident Report" dated
9/20/12 documented, "...Describe Injury: Injury
UKO (unknown origin)... Narrative of Event...
Resident was observed standing in the doorway
of her room. She was noted to have BRB [bright
red blood] coming from her [R] [right] eyebrow...
Condition of Resident... noted about a 1 inch
laceration..." Review of the "Resident Incident
Follow-up Report" dated 9/24/12 documented the
Administrator section of the report was blank.

Observations in Resident #254's room on 10/4/12
at 8:45 AM, revealed Resident #254 sitting on her
bed and responded inappropriately to questions.

During an interview in the dining room on 10/3/12
at 2:10 PM, the DON was asked who is the abuse
coordinator. The DON stated, "...the
Administrator is the abuse coordinator..." The
DON was asked what what her role was. The
DON stated, "staff notify me and the
administrator... staff initiate incident report... then
report it to corporate..." The DON was asked
what type of events do you report to the state.
The DON stated, "...injury of unknown origin if
you can't conclude where it came from, abuse of
any type if it is substantiated after our
investigation... Administrator decides when to
report on a case by case basis... any crimes
against the resident... misappropriation..." The
F 225 Continued From page 5

DON was asked if the injury of unknown origin incident concerning Resident #254 was reported to the state. The DON stated, "...this was not reported..."

During an interview in the Administrator's office on 10/3/12 at 2:35 PM, the Administrator was asked what types of incidents were reported to the state. The Administrator stated, "...verbal, misappropriation, intimidation, any neglect, any mean spiritedness, injuries of unknown origin...if we didn't know where the issue was, if the resident was bed bound..." The Administrator was asked if the injury of unknown origin incident concerning Resident #254 was reported to the state. The Administrator stated, "...no, it was not reported...I need to investigate why..." The Administrator was asked what is the process for investigating an injury of unknown origin. The Administrator stated, "...interview the resident, staff, depending on the type of incident...if it was an injury of unknown origin, we would report it in the clinical record and morning report every day...then a determination is made..."

During an interview in the 600 hall nurses' station on 10/4/12 at 8:20 AM, Nurse #11 was asked what was the facility's procedure for addressing an injury of unknown origin. Nurse #11 stated, "...if witnessed, we do an investigation assessment...do an incident report...give it to my supervisor..."

During an interview in the small dining room on 10/4/12 at 10:36 AM, Nurse #12 was asked what was the facility's procedure for addressing an injury of unknown origin. Nurse #12 stated, "...once the incident occurs...the incident report is..."
F 225 | Continued From page 6 
completed... we talk about it the next morning at 
the clinical meeting... determine if it was an injury 
of unknown origin..." Nurse #12 was asked which 
injuries of unknown origin should be reported to 
the state. Nurse #12 stated, "...all of them..." 
Nurse #12 was asked if the incident which 
occurred on 9/20/12 was reported to the state. 
Nurse #12 stated, "No."

The facility failed to report an incident of an injury 
of an unknown origin.

F 241 | 483.15(a) DIGNITY AND RESPECT OF 
INDIVIDUALITY 
The facility must promote care for residents in a 
manner and in an environment that maintains or 
enhances each resident's dignity and respect in 
full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by: 
Based on policy review, observation and 
terview, it was determined 2 of 18 Certified 
Nursing Assistants (CNA #1 and #3) observed 
during meal delivery failed to respect the 
residents' privacy by not waiting for the resident's 
permission prior to entering their room after 
knocking.

The findings included:

1. Review of the facility "Resident's Rights" policy 
documented, "...General Guidelines... Rights... 
Have your privacy respected by all employees..."

2. Observations outside room 308 on 1/11/12 at 
11:33 AM, CNA #1 entered room 308 as she was
### F 241
Continued From page 7

knocking. CNA #1 entered the room without waiting for permission to enter.

3. Observations outside room 308 on 1/1/12 at 11:45 AM, CNA #3 entered room 308 as she was knocking. CNA #3 entered the room without waiting for permission to enter.

4. During an interview at the 100-400 hall nurses' station on 10/4/12 at 9:40 AM, the Director of Nursing (DON) was asked what her expectations were for knocking before entering a resident's room. The DON stated, "...would expect them [staff] to knock and wait to enter... would expect to wait for permission to enter room..."

### F 246
483.18(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES

A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation and interview, it was determined the facility failed to provide a functioning call light within reach of 1 of 20 (Resident #112) sampled residents included in the stage 2 review.

The findings included:

- Medical record review for Resident #112

### F 241
Observations of twenty staff members on dignity and respect upon entering resident rooms will be conducted five times a week times two weeks, then two times a week times two months and/or 100% compliant by the Director of Nursing and/or Nursing Supervisors. The findings will be reported by the Director of Nursing to the Quality Assurance Performance Improvement committee for 3 months or until 100% compliance obtained. Members of the Quality Assurance Performance Improvement Committee are the Administrator, Medical Director, Director of Nursing, Social Services, Activities Director, Quality Assurance Nurse, Dietary Manager, Minimum Data Set Registered Nurse, Medical Records, Rehab Manager, Maintenance Director, and Environmental Services.

### F 246

1. Resident #112 was interviewed 10/16/12 by Social Worker about preferences as related to call light with no adverse outcome noted.

Resident #112's call light was repaired by Maintenance Director on 10/2/12.

Nurse #5 was in-serviced on positioning of call lights on 10/15/12 by Nurse Manager.

Nurse #6 was in-serviced and report malfunctioning call lights and positioning of call lights on 10/15/12 by Nurse Manager.

2. Audits of functioning of call lights and placement of call lights was completed 10/2/12-10/24/12 by Maintenance Director, Director of Nursing and/or Nursing Supervisors.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

445218

(XII) MULTIPLE CONSTRUCTION
A. BUILDING
B. WANG

(XII) DATE SURVEY COMPLETED

10/04/2012

NAME OF PROVIDER OR SUPPLIER
GRACE HEALTHCARE OF CORDOVA

STREET ADDRESS, CITY, STATE, ZIP CODE
965 GERMANTOWN PKWY
CORDOVA, TN 38018

(XIV) ID PREFIX

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR L5C IDENTIFYING INFORMATION)

F 245 Continued From page 8 documented an admission date of 6/27/12 with diagnoses of Quadriplegia, Anemia, Pressure Ulcer, Chronic Skin Ulcer, Dermatophytosis, Neurogenic Bladder, Chronic Obstructive Pulmonary Disease and Benign Prostatic Hyperplasia.

Observations in Resident #112’s room on 10/2/12 at 8:15 AM and 10:30 AM, revealed a broken call light out of reach of Resident #112.

During an interview in Resident #112’s room on 10/2/12 at 8:16 AM, Resident #112 was asked if he had a working call light. Resident #112 stated, "...No... been about a month since it worked... they tried to fix it but it would fall off... I just yell out and the nurse comes..."

During an interview at nurses’ station 2 on 10/2/12 at 8:45 AM, Nurse #5 was asked how Resident #112 used a call light. Nurse #5 stated, "...He can use the call light... he blows into it... it should be positioned in front of him so he could blow into it..."

During an interview in Resident #112’s room on 10/2/12 at 10:40 AM, Nurse #6 was asked if the call light for Resident #112 was in a working condition. Nurse #6 looked at the call light and stated, "...Somebody took the cap off... it’s broke... Must have took it off to clean it and broke it. It’s wrapped around the bed, clogged with dust..."

Observations in Resident #112’s room on 10/2/12 at 4:53 PM, revealed Resident #112 lying in bed, with the call light positioned out of reach behind the resident’s head.

F 246 Licensed nurses, Certified Nursing Assistants, Environmental Services, Social Services, Activities, Maintenance, Therapy Department, Dietary, Administration, and the Business Office were interviewed by the Director of Nursing and/or Staff development 10/3/12-10/24/12 on reporting of call light malfunctions and proper placement.

A. Audits of twenty residents call lights related to function and position will be conducted five times a week times two weeks, then three times a week times two weeks, then two times a week times two months and/or until 100% compliance obtained by the Director of Nursing and/or Nursing Supervisors. The findings will be reported by the Director of Nursing to the Quality Assurance Performance Improvement committee for 3 months or until 100% compliance obtained. Members of the Quality Assurance Performance Improvement Committee are the Administrator, Medical Director, Director of Nursing, Social Services, Activities Director, Quality Assurance Nurse, Dietary Manager, Minimum Data Set Registered Nurse, Medical Records, Rehab Manager, Maintenance Director, and Environmental Services.
F 246 Continued From page 9

During an interview in Resident #112's room on 10/2/12 at 5:00 PM, Resident #112 was asked if his call light had been repaired. Resident #112 stated, "...it is working..." Resident #112 was asked if he can use it, the way it is positioned. Resident #112 stated, "...No, it's behind my head. The doctor was in here and moved it back there..."  

Observations in Resident #112's room on 10/3/12 at 8:09 AM, revealed Resident #112's call light was positioned out of reach behind the resident's head.

During an interview in Resident #112's room on 10/3/12 at 8:10 AM, Resident #112 was asked if he could use his call light where it is located. Resident #112 stated, "...they moved it so I could have my coffee. If I need something I will have to yell out..."  

F 252

483.15(f)(1)
SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT

The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to provide a homelike environment by leaving meals on trays after being served and serving drinks in styrofoam cups to the residents on 3 of 8 halls
F 252: Continued From page 10
(200, 300 and 600 halls).

The findings included:

1. Observations of the lunch meal on the 200 hall
   on 10/1/10 at 11:35 AM, revealed drinks were
   served in styrofoam cups to the residents on
   the 200 hall.

2. Observations of the lunch meal on the 300 hall
   10/1/12 at 11:33 AM, revealed drinks were served
   in styrofoam cups to residents in rooms 305, 308,
   310 and 312.

3. Observations of the lunch meal in the 600 hall
   dining room on 10/3/12 at 11:35 AM, revealed
   drinks, plates and bowls of food were left on the
   trays after being served to the residents in the
   600 hall dining room.

4. During an interview in the kitchen on 10/3/12
   at 11:30 AM, the Certified Dietary Manager
   stated, "...we are constantly ordering glasses
   because the residents will keep them in their
   rooms...we have to use styrofoam cups until the
   glasses come in...."

5. During an interview in the 100-400 hall on
   10/4/12 at 9:40 AM, the Director of Nursing
   (DON) was asked what her expectations were for
   meal service. The DON stated, "...would expect
   them to take the items off the tray to serve the
   residents in the dining room..."

F 252, 3. Licensed nurses, Certified Nursing Assistants,
   Environmental Services, Social Services, Activities,
   Maintenance. Therapy Department, Dietary,
   Administration, and the Business Office
   were in-serviced by the Director of Nursing.

Dietary Manager and/or Staff Development
10/4/12-10/24/12 on the use of glasses and
removing all items from when in dining rooms.

4. Audit of twenty residents removing dishware
   from food tray and use of glasses will be completed
   5 times a week for 2 weeks, 3 times a week for 2
   weeks, 2 times a week for 4 weeks. 1 time a week
   for 4 weeks and/or until 100% compliance achieved
   by the Dietary Manager, Director of Nursing and/or
   Nursing Supervisor. The findings will be reported
   by the Director of nursing to the Quality Assurance
   Performance Improvement committee for 3 months
   and/or until 100% compliance obtained. Members
   of the Quality Assurance Performance
   Improvement Committee are the Administrator,
   Medical Director, Director of Nursing, Social
   Services, Activities Director, Quality Assurance
   Nurse, Dietary Manager, Minimum Data Set
   Registered Nurse, Medical Records, Rehab
   Manager, Maintenance Director, and
   Environmental Services.

F 278: 483.20(g) - (g) ASSESSMENT

SS=0 ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the
resident's status.
| F 278 | Continued From page 11 |

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:

| F 278 |

1. Resident #11 Minimum Data Set section B was modified by Nurse #1 on 10/3/12 with the correct coding related to vision. No adverse outcomes noted.

   Nurse #1 was in-service on 10/12 about accuracy of Minimum Data Set assessment in regards to section B vision by the Director of Nursing.

2. All residents have the potential to be affected by this citation. Audits of section B of the Minimum Data Set was completed the Nursing Supervisor 10/4/12-10/24/12 for accuracy.

   Minimum Data Set Licensed Nurses and Social Workers were re-serviced by the Director of Nursing and/or Minimum Data Set Registered Nurse on the accurate completion of Section B of the Minimum Data Set 10/4/12-10/24/12.

   As an audit of five Minimum Data Sets will be conducted three times a week times two weeks, then two times a week times two weeks, then one time a week times two months and/or 100% compliant by the Director of Nursing and/or Minimum Data Set Registered Nurse. The findings will be reported by the Director of Nursing to the Quality Assurance Performance Improvement committee for 3 months or until 100% compliance obtained. Members of the Quality Assurance Performance Improvement Committee are the Administrator, Medical Director, Director of Nursing, Social Services, Activities Director, Quality Assurance Nurse, Dietary Manager, Minimum Data Set Registered Nurse, Medical Records, Rehab Manager, Maintenance Director, and Environmental Services.

The findings included:

Medical record review for Resident #11
F 278 | Continued From page 12
documented an admission date of 7/27/12 with
diagnoses of Right Ischemic Pressure Ulcer with
Skin Flap, Convulsions, Paraplegia, Glaucoma,
Cerebrovascular Accident, Suprapubic Catheter,
Intracerebral Hemorrhage and Colostomy.
Review of the MDS assessment dated 8/3/12
documented in section C 500 and vision B 1000
were marked yes, indicating the need of glasses.
The MDS dated 9/12/12 documented in section C
500 and vision B 1000 were coded "2" and the B
1200 was coded as "No", indicating glasses were
not needed.

During an interview in the Social Workers' office
on 10/3/12 at 2:10 PM, the Social Worker stated,
"...he wears glasses... let me see what I can find
out..."

During an interview in the conference room on
10/3/12 at 2:42 PM, Nurse #1 was asked about
Resident #11's visual status. Nurse #1 stated.
"...he did come in with glasses... the 9/12/12 MDS
coding on the vision was miscoded... I will have to
do a modification to this MDS..."

F 280 | 483.20(d)(3), 483.10(k)(2) RIGHT TO
PARTICIPATE PLANNING CARE-REVISE CP

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

F 280 | F180

Resident # 97 was assessed by Nurse Practitioner
on 10/16/12. No adverse findings noted.
Resident #97 care plan was updated by the
interdisciplinary team which consists of the
Director of Nursing, Social Services, Dietary, Unit
Manager, Minimum Data Assessment Nurse and
Activities on 10/15/12.
Resident # 108 was assessed by Nurse Practitioner
on 10/16/12. No adverse findings noted.
Resident #97 care plan was updated by the
interdisciplinary team which consists of the
Director of Nursing, Social Services, Dietary, Unit
Manager, Minimum Data Assessment Nurse and
Activities on 10/15/12.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

GRACE HEALTHCARE OF CODOVA

SUMMARY STATEMENT OF DEFICIENCIES

F 280 Continued From page 13 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, observation and interview, it was determined the facility failed to revise the care plan for falls, range of motion (ROM) or personal hygiene for 3 of 25 (Residents #97, #108 and 210) sampled residents included in the stage 2 review.

The findings included:

1. Medical record review for Resident #57 documented an admission date of 3/20/07 with diagnoses of Hypertension, Cortical Blindness, Psychosis, Anoxic Brain Damage, Dementia, Anxiety, Encephalopathy and Cardiac Arrest. Review of the annual Minimum Data Set (MDS) dated 2/22/12 documented, "...C1000 Cognitive Skills for Daily Decision Making = 3... Severely Impaired... G0400 Functional Limitation of Range of Motion A. Upper Extremity (shoulder, elbow, wrist, hand) = 1 Impairment on one side..." and section J health conditions "J1800: Falls since admit / reentry / prior assessments: any falls = 1" indicating a fall.

Review of a Doctor's progress note dated 8/7/12

STREET ADDRESS, CITY, STATE, ZIP CODE

985 GERMANTOWN PKWY

CORDOVA, TN 38018

ID PREFIX TAG

ID PREFIX TAG

DATE SURVEY COMPLETED

10/04/2012

10/15/11
F 280 | Continued From page 14
documented, "...Resident #97 found on floor-- he fell from his bed... He is blind and @ [at] times he rolls in bed... Several scratches noted..."

Review of a Physician's telephone order dated 9/28/12 documented, "...fall from bed. Bruise above Left eye..."

Review of the care plan dated 9/28/12 documented, "...History of falls with poor safety awareness, blindness... Use of psychoactive medications, seizure disorder..." Falls were documented on the following dates: 6/19/12, 8/7/12, 9/15/12, 9/27/12 and 9/28/12. Care plan interventions were documented as follows:

a. "9/19/12: Monitor for pain and reposition frequently while in bed..."
b. "8/7/12: monitor pain, bed alarm, neuro checks xray..."
c. "9/15/12: Reposition frequently while in bed and monitor for pain..."
d. "9/27/12: Monitor for pain; keep foot of bed elevated, first pt [patient] to be checked at start of each round..."

During an interview at station 1 on 10/4/12 at 8:20 AM, the Director of Nursing (DON) was asked about implementing new interventions following each fall. The DON stated, "...We preach to our nurses they have to do something immediately [new interventions after falls]..."

2. Medical record review for Resident #108 documented an admission date of 7/7/12 with diagnoses of Chronic Kidney Disease, Anemia, Hypertension, Diabetes Mellitus, Mental Disorder, Gastrostomy and Contractures. Review of the MDS dated 7/8/12 documented severe cognitive
F 280 Continued From page 15

Impairment and functional limitation of range of motion (ROM) bilaterally.

Review of the functional maintenance plan dated 7/21/12 documented, "...contractures of multiple joints... Range of Motion passive, Bilat [bilateral] upper extremity and Bilat hands with 25- [to] 50% [percent] passive tolerated splints 1-2 hrs [hours]. Goal: 75% PROM [passive range of motion] of hands 3 hrs tolerance of splints..."

Review of the care plan dated 7/8/12 documented no interventions for ROM or prevention measures to prevent deterioration or prevent further contractures from developing. There was no documentation of splinting include on the care plan.

Observation in Resident #108's room on 10/4/12 at 10:00 AM, revealed Resident #108 was not wearing a splint on either hand.

During an interview at station 3 on 10/3/12 at 2:20 PM, Nurse #7 was asked to describe how certified nursing assistants (CNAs) provide AM care. Nurse #7 stated, "...during new orientation CNAs are instructed how to complete AM care... AM care consists of cleaning/bathing resident, dressing resident and then doing PROM..."

During an interview on 700 hall on 10/4/12 at 10:45 AM, CNA #10 was asked what AM care would be for Resident #106. CNA #10 stated, "...AM care would be face cleaning, mouth swabbing, bath or shower, and dressing..." CNA #10 was asked about ROM. CNA #10 stated, "...oh yes, with flexing and extending arms..."

CNA #10 was asked about Resident #108's hand
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 280</td>
<td></td>
<td>Continued From page 16</td>
</tr>
</tbody>
</table>

splints. CNA #10 stated, "...the splints are applied at 10:00 AM..." CNA #10 was asked where the splints were. CNA #10 stated, "...the splints are in the drawer..."

3. Medical record review for Resident #210 documented an admission date of 8/4/11 with diagnoses of Altered Mental Status, Anemia, Hypertension, Hypothyroidism, Muscle Weakness and Symbolic Dysfunction. Review of the quarterly MDS dated 4/8/12 and the annual MDS dated 7/1/12 documented, "...Section G-Functional Status...J. Personal hygiene- how resident maintains personal hygiene including... brushing teeth... 3= Extensive assistance..."

Review of the care plan dated 9/18/12 documented, "...I require assistance with self care task (personal hygiene)... Require limited to extensive assistance..." There was no documentation on the care plan for interventions for hygiene and grooming.

Review of the completed care tasks dated 9/1/12 through 10/2/12 documented, "...Bathing (includes hair care, nail care, mouth care, and shave as needed)..." and dates recorded as having occurred were 9/3/12, 9/5/12, 9/7/12, 9/12/12, 9/14/12, 9/17/12, 9/19/12, 9/21/12, 9/24/12, 9/26/12, 9/28/12 and 10/1/12.

During an interview in Resident #210's room on 10/1/12 at 4:45 PM, Resident #210 was asked how often her teeth, dentures and mouth were cleaned. Resident #210 stated, "...never..." Resident #210 was asked if staff helped as necessary to clean her teeth. Resident #210 stated, "...they don't help me with my teeth..."
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PROCESSED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION)</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPLICABLE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 280</td>
<td>Continued From page 17</td>
<td>F 280</td>
<td></td>
</tr>
<tr>
<td></td>
<td>During an interview in the conference room on 10/3/12 at 3:30 PM, the Director of Nursing (DON) was asked how often she expect oral care and brushing teeth to occur or be provided to the residents by the staff. The DON stated, &quot;...every morning, after meals, like you would do for yourself...&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>During an interview in the conference room on 10/3/12 at 4:50 PM, Nurse #2 was asked to look at the care plan and locate hygiene and grooming interventions. Nurse #2 stated, &quot;...I don't see anything...&quot;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 282</td>
<td>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</td>
<td>F 282</td>
<td></td>
</tr>
<tr>
<td>SS=O</td>
<td>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>This REQUIREMENT is not met as evidenced by;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Based on policy review, medical record review, observation and interview, it was determined the facility failed to follow the care plan for mouth and nail care for 1 of 25 (Resident #112) residents included in the stage 2 review.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The findings included:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Review of the facility's &quot;Care of Fingernails/Toenails&quot; policy documented, &quot;...The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections...Nail care includes daily cleaning and</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FORM CMS-2587(02-95) Previous Versions Obsolete Event ID: DXX011 Facility ID: TN9077 If continuation sheet Page 18 of 29
**F 282** Continued From page 18

regular trimming..."

Review of the facility's "Mouth Care" policy documented, "...The purposes of this procedure are to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent infections of the mouth..."

2. Medical record review for Resident #112 documented an admission date of 6/27/12 with diagnoses of Quadriplegia, Anemia, Pressure Ulcer, Chronic Skin Ulcer, Dermatophytosis, Neurogenic Bladder, Chronic Obstructive Pulmonary Disease and Benign Prostatic Hypertrophy. Review of the care plan dated 6/21/11 documented, "...Dependent on staff for ADLs (activities of daily living) [related to] quadriplegic... Anticipate and meet resident's needs as necessary... Oral care daily and prn as needed."

Observations in Resident #112's room on 10/2/12 at 4:55 PM, revealed Resident #112 lying in bed with long fingernails, malodorous breath and noticeable plaque and discoloration to teeth.

Observations in Resident #112's room on 10/3/12 at 4:10 PM, revealed Resident #112 wearing a hospital gown with long fingernails.

During an interview in Resident #112's room on 10/1/12 at 4:33 PM, Resident #112 was asked how often are your teeth/dentures/mouth cleaned. Resident #112 stated, "...Three times a week..."

During an interview in Resident #112's room on 10/2/12 at 4:55 PM, in Resident #112 was asked if he wanted his fingernails long. Resident #112
<table>
<thead>
<tr>
<th>F 282</th>
<th>Continued From page 19</th>
<th>F 282</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>...No, not this long... the CNA [Certified Nursing Assistant] that usually trims my nails was moved to the other hall... I asked the nurse but she said she didn’t have any clippers...</td>
<td></td>
</tr>
<tr>
<td></td>
<td>During an interview in Resident #112’s room on 10/3/12 at 4:10 PM, Resident #112 was asked when his nails were last trimmed. Resident #112 stated, &quot;...about a month ago...&quot;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>During an interview in the unit manager’s office on 10/3/12 at 4:25 PM, Nurse #6 was asked if there was documentation of oral care and nail care provided to Resident #112. Nurse #6 stated, &quot;...It’s documented in the smart charting but it’s all under AM [care] and HS [hour of sleep] care... So if one of the areas was not done there is not a way to differentiate... to say all areas were done I don’t know... It can’t be broken down...&quot;</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>F 312</th>
<th>483.25(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</td>
</tr>
<tr>
<td></td>
<td>This REQUIREMENT is not met as evidenced by:</td>
</tr>
<tr>
<td></td>
<td>Based on policy review, medical record review, observation and interview, it was determined the facility failed to provide mouth and nail care for 1 of 20 (Residents #112) residents included in the stage 2 review.</td>
</tr>
</tbody>
</table>
|       | The findings included:

<table>
<thead>
<tr>
<th>F 312</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Resident #112 was assessed by Nurse Manager on 10/4/12. No adverse findings noted. Resident nail care and mouth care was completed by Nurse Manager on 10/4/12.</td>
</tr>
<tr>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>All residents have the potential to be affected by this citation. An audit of all residents nail and mouth care was completed 10/9/12-10/24/12 by Director of Nursing Assistant Director of Nursing and/or Nursing Supervisors.</td>
</tr>
</tbody>
</table>
**F 312 Continued From page 20**

Review of the facility’s "Mouth Care" policy documented, "...The purposes of this procedure are to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent infections of the mouth..."

Review of the facility’s "Care of Fingernails / Toenails" policy documented, "...The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections... Nail care includes daily cleaning and regular trimming..."

Medical record review for Resident #112 documented an admission date of 6/27/12 with diagnoses of Quadriplegia, Anemia, Pressure Ulcer, Chronic Skin Ulcer, Dermatophytosis, Neurogenic Bladder, Chronic Obstructive Pulmonary Disease and Benign Prostatic Hypertrophy. Review of the care plan dated 6/21/11 documented, "...Dependent on staff for ADLs r/t [related to] quadriplegic... Anticipate and meet resident's needs as necessary... Oral care daily and pm [as needed]..."

Observations in Resident #112's room on 10/2/12 at 4:55 PM, revealed Resident #112 lying in bed with long fingernails, malodorous breath and noticeable plaque and discoloration to teeth.

Observations in Resident #112's room on 10/3/12 at 4:10 PM, revealed Resident #112 wearing a hospital gown with long fingernails.

During an interview in resident #112's room on 10/1/12 at 4:33 PM, Resident #112 was asked how often are your teeth/dentures/mouth cleaned.
<table>
<thead>
<tr>
<th>Date of Occurrence</th>
<th>F 312</th>
<th>F 318</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/4/2012</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**F 312**  
Continued From page 21

Resident #112 stated, "...Three times a week..."

During an interview in Resident #112's room on 10/2/12 at 4:55 PM, in Resident #112 was asked if he wanted his fingernails long. Resident #112 stated, "...No, not this long... the CNA [Certified Nursing Assistant] that usually trims my nails was moved to the other hall... I asked the nurse but she said she didn't have any clippers..."

During an interview in Resident #112's room on 10/2/12 at 4:10 PM, Resident #112 was asked when his nails were last trimmed. Resident #112 stated, "...about a month ago..."

During an interview in the unit manager's office on 10/3/12 at 4:25 PM, Nurse #6 was asked if there was documentation of oral care and nail care provided to Resident #112. Nurse #6 stated, "...It's documented in the smart charting but it's all under AM [care] and HS [hour of sleep] care... So if one of the areas was not done there is not a way to differentiate... to say all areas were done I don't know... It can't be broken down..."

**F 318**  
483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION

Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

This REQUIREMENT is not met as evidenced by:

---

*Event ID: OWXX11  Facility ID: TFM397  If continuation sheet Page 22 of 29*
**NAME OF PROVIDER OR SUPPLIER**

GRACE HEALTHCARE OF CORDOVA

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

955 GERMANTOWN PKWY

CORDOVA, TN 38018

<table>
<thead>
<tr>
<th>F 318</th>
<th>Continued From page 22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on medical record review, observation and interview, it was determined the facility failed to utilize measures to increase or prevent a further decrease in range of motion for 2 of 20 (Residents #97 and 108) residents included in the stage 2 review.</td>
<td></td>
</tr>
</tbody>
</table>

The findings included:

1. Medical record review for Resident #97 documented an admission date of 3/30/07 with diagnoses of Hypertension, Cortical Blindness, Psychosis, Anoxic Brain Damage, Dementia, Anxiety, Encephalopathy and Cardiac Arrest. Review of the annual Minimum Data Set (MDS) dated 2/22/12 documented, "...C1000 Cognitive Skills for Daily Decision Making=3... Severely impaired... 304000 Functional Limitation of Range of Motion A. Upper Extremity (shoulder, elbow, wrist, hand)=1 Impairment on one side..."

Review of the care plan dated 7/30/12 documented, "...I require staff assistance with my mobility n/r [related to] cognition and contractures... I require passive range of motion [PROM] exercises..."

Review of physician's orders dated 10/1/12 through 10/31/12 documented, "...Up in a geri chair as tolerated... PROM to all extremities with ADL [Activities of Daily Living] care every shift... Restorative nursing to apply orthotic knee splint to BLE [bilateral lower extremities] 5-[to] 6 hrs [hours]/day for contracture management... Resident to use foot cradle while in gerichair for positioning..."

Observations in Resident #97's room on 10/31/12

<table>
<thead>
<tr>
<th>F 318</th>
<th>All residents have the potential to be affected by this issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>An audit of residents for a decline of activities of daily living and range of motion completed 10/15/12-10/24/12 by nursing and therapy department.</td>
<td></td>
</tr>
</tbody>
</table>

3. Licensed nurses, Certified Nursing Assistants, and Therapy Department were re-instructed by the Director of Nursing and/or Staff Development 10/4/12-10/24/12 regarding preventing decrease in range of motion and proper use of splints.

4. Observations of range of motion and use of splints to prevent a decrease in range of motion will be conducted three times a week times two weeks, then twice a week times two weeks, then once a week times two months and/or until 100% compliance obtained by the Director of Nursing. The findings will be reported by the Director of Nursing to the Quality Assurance Performance Improvement committee for 3 months or until 100% compliance obtained. Members of the Quality Assurance Performance Improvement Committee are the Administrator, Medical Director, Director of Nursing, Social Services, Activities Director, Quality Assurance Nurse, Dietary Manager, Minimum Data Set Registered Nurse, Medical Records, Rehab Manager, Maintenance Director, and Environmental Services.
Continued From page 23

at 11:30 AM revealed Resident #97 seated in a geri chair with no orthotic knee splint and no foot cradle in use.

During an interview at nurses station 3 on 10/3/12 at 2:20 PM, Nurse #7 was asked to describe morning care. Nurse #7 stated, "...AM Care consists of cleaning and bathing resident, dressing resident and then doing PROM..."

During an interview in the 700 hall on 10/3/12 at 11:35 AM Certified Nursing Assistant (CNA #7) was asked to describe Resident #97’s AM care. CNA #7 stated,...skin care, brushed teeth... asked him to raise his arm while I put shirt on and raise his leg to put his pants on... He is able to move all extremities and extend them..." CNA #7 was asked about a knee splint for Resident #97’s legs. CNA #7 confirmed there is no splint on Resident #97’s legs.

2. Medical record review for Resident #106 documented an admission date of 7/2/12 with diagnoses of Chronic Kidney Disease, Anemia, Hypertension, Diabetes Mellitus, Mental Disorder, Gastrostomy and Contractures. Review of the MDS dated 7/8/12 documented severe cognitive impairment and functional limitation of range of motion bilaterally.

Review of the functional maintenance plan dated 7/21/12 documented, "...contractures of multiple joints... Range of Motion passive, Bilat [bilateral] upper extremity and Bilat hands with 25-50% [percent] passive tolerated splints 1-2 hrs [hours]. Goal: 75% PROM of hands 3 hrs tolerance of splints..."
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F318</td>
<td>Continued From page 24</td>
<td>Observation in Resident #108's room on 10/4/12 at 10:00 AM, revealed Resident #108 was not wearing a splint on either hand. During an interview at station 3 on 10/3/12 at 2:20 PM, Nurse #7 was asked to describe how CNAs provide AM care. Nurse #7 stated, &quot;...during new orientation CNAs are instructed how to complete AM care... AM care consists of cleaning/bathing resident, dressing resident and then doing PROM...&quot; During an interview in the rehab gym on 10/4/12 at 10:20 AM, the Rehab Director was asked about Resident #108's ROM goals. The Rehab Director stated, &quot;...Resident #108 has had a PT [Physical Therapy] Screening... has a Functional Maintenance Plan...&quot; During an interview on 700 hall on 10/4/12 at 10:45 AM, CNA #10 was asked what AM care would be for Resident #108. CNA #10 stated, &quot;...AM care would be face cleaning, mouth swabbing, bath or shower, and dressing...&quot; CNA #10 was asked about ROM. CNA #10 stated, &quot;...oh yes, with flexing and extending arms...&quot; CNA #10 was asked about Resident #108's hand splints. CNA #10 stated, &quot;...the splints are applied at 10:00 AM...&quot; CNA #10 was asked where the splints were. CNA #10 stated, &quot;...the splints are in the drawer...&quot;</td>
<td>F371</td>
<td>483.35(l) FOOD PROCUREMENT, STORE/PREPARE SERVE - SANITARY</td>
<td>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 371</td>
<td>Continued From page 25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) Store, prepare, distribute and serve food under sanitary conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to serve food under sanitary conditions when 4 of 19 staff members (Certified nursing assistants (CNAs) #1, 2 and 7 and Nurse #10) observed during dining handled food with their bare hands or failed to wash their hands after handling resident equipment prior to setting up the residents' meal trays.

The findings included:

1. Observations during the lunch meal in room 308 on 10/1/12 at 11:33 AM, CNA #1 lowered the bed, raised the head of the bed, set up the tray, placed the overbed table in front of the resident, removed the paper from the straw, handled the straw with her bare hands, stirred the sugar in the tea with the straw, opened the butter and mixed it into the potatoes, placed the napkin on the resident's chest and removed the roll from the wrapper with her bare hands.

2. Observations in room 302 on 10/1/12 at 11:40 AM, CNA #2 set up the tray for the resident and removed the roll from the paper wrapper, handling the roll with her bare hands.

3. Observations in room 240 on 10/2/12 at 5:31 PM, CNA #7 placed the tray on the overbed table,
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA

IDENTIFICATION NUMBER: 445218

(X2) MULTIPLE CONSTRUCTION

A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED

STREET ADDRESS, CITY, STATE, ZIP CODE

915 GERMANTOWN PKWY
CORDOVA, TN 38018

NAME OF PROVIDER OR SUPPLIER

GRACE HEALTHCARE OF CORDOVA

DATE

10/04/2012

F 371

Continued from page 26 touched the bed linens near the resident’s feet, then set up the tray. CNA #7 did not wash hands. CNA #7 exited to the hallway and opened the door of the meal cart without washing hands.

4. Observations in room 238 on 10/2/12 at 5:36 PM, Nurse #10 assisted the resident in B bed, touched the resident on the head and arm and then left the room. Nurse #10 returned to the room and began feeding the resident in A bed. Nurse #10 did not wash her hands between resident contact.

6. During an interview in the Nurse Practitioner’s office on 10/4/12 at 10:35 AM, the Director of Nursing (DON) was asked what she expected the staff to do for hand hygiene during tray delivery. The DON stated, “...If they touch a resident or anything in the room they need to wash their hands before touching the tray and feeding and before going to another resident.”

483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY

Bedrooms must be designed or equipped to assure full visual privacy for each resident.

In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.

This REQUIREMENT is not met as evidenced by:

Based on observation and interview, it was determined the facility failed to assure full visual for 4 weeks and/or until 100% compliance achieved by the Director of Nursing and/or Nursing Supervisor. The findings will be reported by the Director of Nursing to the Quality Assurance Performance Improvement committee for 3 months or until 100% compliance obtained. Members of the Quality Assurance Performance Improvement Committee are the Administrator, Medical Director, Director of Nursing, Social Services, Activities Director, Quality Assurance Nurse, Dietary Manager, Minimum Data Set Registered Nurse, Medical Records, Rehab Manager, Maintenance Director, and Environmental Services.

483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY

Bedrooms must be designed or equipped to assure full visual privacy for each resident.

In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.

This REQUIREMENT is not met as evidenced by:

Based on observation and interview, it was determined the facility failed to assure full visual

FORM CMS-2557(02-99) Previous Versions Obsolete
Event ID: DW0011
Facility ID: TN7507
If continuation sheet Page 27 of 29
Continued From page 27

F 460.1 to privacy for residents in 23 of 121 (Rooms 207, 209, 211, 212, 216, 219, 225, 227, 229, 231, 232, 233, 234, 235, 236, 237, 239, 240, 302, 310, 625, 627, and 701) resident rooms.

The findings included:


During an interview in room 238 on 10/4/12 at 10:17 AM, certified nursing assistant (CNA #5) was asked if the privacy curtains for bed A provided full privacy. CNA #5 stated, "...it won't go across. There is something in the track and it's too short. It won't go all the way around..."

During an interview in room 232 on 10/4/12 at 10:20 AM, when asked if the privacy curtain for bed A provided full privacy. CNA #6 stated, "...it's hung. It won't go..."

During an interview outside room 209 on 10/4/12 at 11:15 AM, the Administrator was asked about the lack of full visual privacy. The Administrator stated, "...I will take care of that..."

2. Observations during the initial tour on 10/1/12 beginning at 9:30 AM revealed the following:
   a. Room 219 - the privacy curtain did not provide complete visual privacy around the A bed, with candy cane configuration around the A Bed.
   b. Rooms 302, 310 and 701 - the middle curtain track extended down the middle of the room and stopped one foot from the end of room. The
<table>
<thead>
<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LIC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 460</td>
<td></td>
<td>Continued From page 28 curtains do not encircle the second bed.</td>
<td>F 460</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. Rooms 625 and 627 - Privacy curtain did not provide complete visual privacy around the A bed with candy cane configuration around the A Bed. The middle curtain track came down the middle of the room and stopped at the foot of the bed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>