**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES**  
**ND PLAN OF CORRECTION**

(X1) PROVIDER/SUPPLIER/Clinic IDENTIFICATION NUMBER:

445425

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

(X3) DATE SURVEY COMPLETED

08/07/2013

---

**NAME OF PROVIDER OR SUPPLIER**

MILLINGTON HEALTHCARE CENTER

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

5081 EASLEY AVENUE  
MILLINGTON, TN 38053

---

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 278 SS=D</td>
<td>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</td>
<td>F 278</td>
<td>The submission of this Plan of Correction is not to be construed in any way as an admission to the citations nor the finding of the facts and is submitted as mandated by federal law.</td>
<td></td>
</tr>
</tbody>
</table>

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 and interview, it was determined the facility failed to accurately assess residents for urinary continence for 1 of 28 (Resident #55) sampled residents reviewed of the 28 residents included in the stage 2 review.

---

**RECEIVED**  
**SEP 11 2013**

---

**FACILITY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

**DATE**  
8/16/13

---

**CMS-2587(02-99) Previous Versions Obsolete**  
**Event ID:** TPGS11  
**Facility ID:** TN7931  
**If continuation sheet Page 1 of 11**
The findings included:

Medical record review for Resident #55 documented an admission date of 3/1/13 with diagnoses of Hemiplegia of the Dominant Side (Right), Lack of Coordination, Cognitve Deficits, Aphasia, Cerebrovascular Disease, Hypertension, Diabetes Mellitus, History of Fall, Dementia, Insomnia, Reflux Esophagitis, Hyperlipidemia, Osteoporosis and Arthritis. Review of the quarterly Minimum Data Set (MDS) dated 6/8/13 documented Resident #55 was always incontinent with no episodes of continent voiding. Review of the bowel and bladder assessment dated 6/8/13 documented Resident #55 was frequently incontinent of bladder, was aware of the need to void, and was able to be toileted most of the time. Review of the point of care (POC) documentation by the Certified Nursing Assistants (CNA) for Resident #55 revealed Resident #55 had control of urinary bladder function on 5/1/13, 5/4/13, 5/8/13, 5/9/13, 5/11/13, 5/27/13, 5/28/13 and 5/30/13. Resident #55’s MDS dated 6/8/13 assessed Resident #55 as always incontinent. The 6/8/13 assessment was inaccurate, due to the resident is frequently incontinent not always incontinent.

During an interview at the A and B nurses’ station on 8/6/13 at 2:19 PM, Nurse #3 was asked to explain Resident #55’s urinary continence. Nurse #3 stated, "I think most of the time she may ask to go [urinate in the toilet]..."

During an interview at the A and B hall nurses’s station on 8/6/13 at 2:35 PM, CNA #1 was asked to explain Resident #55’s urinary continence. CNA #1 stated, "I would say she is frequently incontinent... sometimes she will ask to go [to the
Continued From page 2

toilet] and will go [urinate] when I take her to the
bathroom..."

During an interview in the MDS office on 8/7/13 at
1:50 PM, Nurse #1 was asked if the quarterly
MDS dated 6/8/13 documentation for bladder
incontinence for Resident #55 was accurate.
Nurse #1 stated, "She's [Resident #55] not
always incontinent... that's frequently
[incontinent]... I put always [incontinent] on there
[6/8/13 MDS]... it should be frequently
incontinent..."

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
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

483.20(d)(3), 483.10(k)(2)

Right To Participate Planning Care-Revise CP

1. Resident assessed and found to have no
significant physical or psychological negative
outcomes due to falls. MDS nurses reviewed
other residents with falls and interventions on
care plan as indicated.

2. Nurses educated on 8/8/13 regarding falls and
the importance of new interventions needing
to be put into place with each fall.

3. DON discussed with family on 8/8/13 the
resident's falls, removing more restrictive
interventions in an effort to reduce falls
and injuries.
F 280 Continued From page 3
by:

Based on policy review, medical record review and interview, it was determined the facility failed to revise the care plan to reflect new interventions after each fall for 1 of 3 (Resident #129) sampled residents reviewed of the 28 residents included in the stage 2 review.

The findings included:

Review of the facility's falls protocol policy documented, "...the Falls/Risk for care plan will be revised..."

Review of the facility's "Change in Condition Report - Post Fall Investigation Summary - Guidelines for Completion" documented, "...Purpose: To assess individual condition after a fall occurs and to identify the reason and/or risk factors for the fall in order to prepare a plan of care to reduce the potential for future falls..."

Medical record review for Resident #129 documented an admission date of 5/9/13 with diagnoses of Atrial Fibrillation, Dysphagia, Hypertension, Esophagitis, History of Urinary Tract Infection, Hypopotassemia, Edema, Insomnia and History of Falls. Review of the Minimum Data Set (MDS) with an assessment reference date (ARD) of 5/6/13 section C for cognition was coded as "03" indicating severely impaired cognition skills. Review of the MDS with an ARD of 6/4/13 section C was coded as "03" and section J800 was coded as "yes" indicating one fall since prior assessment.

Review of the fall risk assessment dated 5/9/13 was coded with a score of 12. A score greater than 12 indicates the resident is at a high risk for
Continued From page 4

Falls. Resident #129 had the following falls and following interventions:

a. 5/15/13 - Bed/Chair alarm - no injuries.
b. 5/18/13 - Lap buddy - no injuries.
c. 6/4/13 - Nonskid socks - no injuries.
d. 6/13/13 - No intervention documented - no injuries.
e. 6/20/13 - Cushion in wheelchair (w/c) to decrease space between resident and lap buddy - no injuries.
f. 7/13/13 - Dycem cushion to w/c to prevent sliding - no injuries.
g. 7/10/13 - Lap buddy and chair alarm reapplied - no injuries.
h. 7/17/13 - No intervention documented - no injuries.
i. 7/25/13 - Lap buddy and w/c alarm reapplied - no injuries.

During an interview in the Director of Nursing's (DON) office on 8/6/13 at 3:10 PM, the DON was asked about fall interventions for the falls on 6/13/13, 7/17/13 and 7/25/13. The DON stated, "I don't see an intervention on the care plan for that fall [referring to the fall on 6/13/13]. Fall on 7/17/13 she was placed back in wheelchair, don't see an intervention. There should have been a different intervention for the fall on 7/25/13..."

There were no interventions on the care plan for the falls on 6/13/13, 7/17/13 and there was not a new intervention for the fall on 7/25/13.

F 323 483.25(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...
### Continued From page 5

adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review and interview, it was determined the facility failed to implement interventions for falls for 1 of 3 (Resident #129) sampled residents reviewed of 7 residents with falls.

The findings included:

Review of the facility's falls protocol policy documented, "...the Falls/Risk for care plan will be revised..."

Review of the facility's "Change in Condition Report - Post Fall Investigation Summary Guidelines for Completion" documented, "...Purpose: To assess individual condition after a fall occurs and to identify the reason and/or risk factors for the fall in order to prepare a plan of care to reduce the potential for future falls..."

Medical record review for Resident #129 documented an admission date of 5/9/13 with diagnoses of Atrial Fibrillation, Dysphagia, Hypertension, Edema, History of Urinary Tract Infection, Hypopotassemia, Esophageitis, Insomnia and History of Falls. Review of the Minimum Data Set (MDS) with an assessment reference date (ARD) of 5/6/13 section C - cognition was coded as "03" indicating severely impaired cognition skills. Review of the MDS with an ARD of 6/4/13 section C was coded as "03"
F 323 Continued From page 6 and section J1800 was coded as "yes" indicating one fall since prior assessment.

Review of the fall risk assessment dated 5/9/13 was coded with a score of 12. A score greater than 12 indicates the resident is at a high risk for falls. Resident #129 had the following falls and following interventions:

a. 5/15/13 - Bed/Chair alarm - no injuries.
b. 6/18/13 - Lap buddy - no injuries.
c. 6/4/13 - Nonskid socks - no injuries.
d. 6/13/13 - No intervention documented - no injuries.
e. 6/20/13 - cushion in wheelchair (w/c) to decrease space between resident and lap buddy - no injuries.
f. 7/5/13 - Dycem cushion to w/c to prevent sliding - no injuries.
g. 7/10/13 - Lap buddy and chair alarm reapplied - no injuries.
h. 7/17/13 - No intervention documented - no injuries.
i. 7/25/13 - Lap buddy and w/c alarm reapplied - no injuries.

During an interview in the Director of Nursing's (DON) office on 6/6/13 at 3:10 PM, the DON was asked about fall interventions for the falls on 6/13/13, 7/17/13 and 7/25/13. The DON stated, "I don't see an intervention on the care plan for that fall [referring to the fall on 6/13/13]. Fall on 7/17/13 she was placed back in wheelchair, don't see an intervention. There should have been a different intervention for the fall on 7/25/13..."

483.(c)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY

Bedrooms must be designed or equipped to
Continued From page 7

**SUMMARY STATEMENT OF DEFICIENCIES**

(Each deficiency must be preceded by full regulatory or LSC identifying information)

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
</tr>
</thead>
</table>
| F 460         | Continued From page 7

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 provide full visual privacy for residents in 5 of 53 (Rooms 37A, 47A, 57A, 61 A, 66A and 73A) resident rooms.

The findings included:

1. Observations in room 37A on 8/5/13 at 11:08 AM and on 8/7/13 at 7:12 AM, revealed the privacy curtain did not provide full visual privacy.

During an interview in room 37 on 8/7/13 at 10:45 AM, Nurse #2 was shown the resident's privacy curtain. Nurse #2 stated, "Oh! We're short about two feet..."

2. Observations in room 47A on 8/5/13 at 2:03 PM and on 8/6/13 at 12:30 PM, revealed the privacy curtain did not provide full visual privacy.

3. Observations in room 57A on 8/5/13 at 11:31 AM, revealed the privacy curtain did not provide full visual privacy.

4. Observations in room 61A on 8/6/13 at 9:00 AM, revealed the privacy curtain did not provide full visual privacy.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX 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>
</table>
| F 460 | Continued From page 8  
5. Observations in room 66A on 8/5/13 at 2:15 PM, revealed the privacy curtain did not provide full visual privacy.  
6. Observations in room 73A on 8/5/13 at 11:50 AM, revealed the privacy curtain did not provide full visual privacy.  
7. During an interview and tour of rooms 57A, 61A and 73A on 8/7/13 beginning at 12:30 PM, the Administrator confirmed the privacy curtains did not provide full visual privacy for the residents in A beds. | | F 460 | | | |
| F 514 | 483.75(1)(1) RES  
RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  
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 policy review, medical record review and interview, it was determined the facility failed to obtain accurate weights for 1 of 4 (Resident #109) sample residents reviewed for significant weight loss of the 29 residents included in the | F 514 | 483.75(1)(1)  
Resident Records-Complete/Accurate/Accessible  
1. Resident's medical record was updated  
8/12/13 to correct erroneous weight.  
2. Resident's record was reviewed to ensure interventions are in place to reduce risk of weight loss. Conducted random weight audit covering past six months to identify if any other residents were affected.  
3. Residents' weights will be monitored weekly through Standards of Care meetings and PRN by IDT to ensure accuracy. |
### Continued From page 9

stage 2 review.

The findings included:

Review of the facility's "Weighing a Resident" policy documented, "Subject: Weighs... All residents will be weighed upon admission, re-admission, and monthly thereafter to establish weight patterns and monitor for changes...

Subject: Weighing a Resident: Standards: To ensure weights are appropriately obtained...

When using a wheelchair scale, deduct the weight of the empty wheelchair prior to recording the weight..."

Medical record review for Resident #109 documented an admission date of 1/4/13 with diagnoses of Gastrostomy, Anemia, Chronic Kidney Disease, Hypertension, Dementia with Behavior Disturbance, Reflux Esophagitis and Osteoarthritis. Review of Resident #109's weight monitoring record documented an admission weight obtained on 1/5/13 of 188.6 pounds (lbs), a weight of 185 lbs obtained on 2/6/13, and a weight of 127.6 lbs obtained on 2/13/13. Nurses notes documented the resident was sent cut to the hospital on 2/11/13 and returned on 2/13/13. The documented weight loss of 57.4 lbs between discharge from the facility to the hospital on 2/11/13 and re-admission to the facility on 2/13/13 triggered the resident for review of the documented significant weight loss. Review of the hospital's "Post Acute Admission Orders" dated 2/11/13 documented an admission weight of 134.2 lbs.

During an interview in the Rehabilitation II office on 9/6/13 at 5:15 PM, the Director of Nursing (DON) was asked why the facility had recorded a
Continued From page 10
weight of 188.6 lbs on admission and the consecutive weight of 185 lbs. The DON stated, "...the CNAs [certified nursing assistants] were using a wheelchair scale and did not subtract the wheelchair weight to obtain an actual body weight."

During an interview in the Assistant Director of Nursing (ADON) office on 8/7/13 at 12:00 PM, the ADON, was asked to explain the documented weight loss of 57.4 lbs. The ADON stated, "...The weights (188.6 lbs and 185 lbs) had the weight of the wheelchair. The wheelchair weight was not subtracted and the CNA kept doing it that way..."