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

**STATEMENT OF DEFICIENCIES**  
**AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLA ID #</th>
<th>(X2) MULTIPLE CONSTRUCTION A: BUILDING</th>
<th>(X3) DATE SURVEY COMPLETED</th>
<th>(X4) ID PREFIX TAG</th>
<th>(X5) COMPLETION DATE</th>
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<tr>
<td>445242</td>
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**NAME OF PROVIDER OR SUPPLIER**  
**GREYSTONE HEALTH CARE CENTER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**  
181 DUNLAP ROAD  
BLOUNTVILLE, TN 37617

**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>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because the provisions of Federal and State law require it.</td>
</tr>
<tr>
<td>F 020</td>
<td>F 202 Documentation for transfer/discharge of resident</td>
</tr>
<tr>
<td></td>
<td>Resident #26 no longer resides in the facility.</td>
</tr>
<tr>
<td>F 202</td>
<td>Admission/Discharge files were reviewed to identify any residents who were involuntarily discharged or transferred since June 26, 2013 and to validate physician documentation of justification of the involuntary discharge. No residents were identified as involuntarily discharged or transferred.</td>
</tr>
</tbody>
</table>

**DOCUMENTATION FOR TRANSFER/DISCHARGE OF RESIDENT**  
483.12(a)(3)

When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.

This **REQUIREMENT** is not met as evidenced by:

Based on medical record review, review of hospital records, review of a thirty-day letter of involuntary discharge and interview, the facility failed to ensure documentation by the physician in the clinical record to justify the involuntary discharge of one resident (ID #26) of thirty-three residents reviewed. The facility's failure resulted in harm for resident #26 causing emotional and mental distress.

**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**  
Administrator  
9/20/13

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 patients. (See instructions.) Except for nursing homes, the findings stated above are disclosed 90 days following the date of survey whether or not a plan of correction is provided.

For nursing homes, the above findings and plans of correction are disclosed 14 days following the date these documents are made available to the facility.

The Administrator will audit twice monthly that the documentation is complete.

Audit results will be reviewed in the monthly Q&A meeting with revision to the plan as deemed appropriate by the QA&A Committee.

**FORM CMS-2567(02-99) Previous Versions Obsolete**  
Event ID: UZJ11  
Facility ID: TN8204
<table>
<thead>
<tr>
<th>F 202</th>
<th>Continued From page 1</th>
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<tbody>
<tr>
<td></td>
<td>The findings included:</td>
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<tr>
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<td>Resident #26 was admitted to the facility on</td>
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<td>January 25, 2007 (six years in facility) with</td>
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<td>diagnoses including Prostatitis, Dementia,</td>
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<td></td>
<td>Psychosis, Anxiety, history of Cerebrovascular</td>
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<td></td>
<td>Accident (Stroke) Benign Prostatic Hypertrophy</td>
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<td>and Hearing Loss.</td>
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<td>Medical record review of the annual Minimum</td>
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<td>Data Set (MDS) dated May 19, 2013 revealed the</td>
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<td>resident had short-term memory impairment and</td>
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<td>modified independence with daily</td>
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<td>decision-making (difficulty in new situations only);</td>
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<td>usually understood (missed some part/rent of</td>
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<td>the message but comprehended most</td>
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<td>conversation); reported trouble falling or staying</td>
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<td></td>
<td>asleep, or sleeping too much); was not</td>
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<td>short-tempered or easily annoyed; had no</td>
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<td></td>
<td>physical or verbal behavior symptoms toward</td>
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<td>others; had no rejection of care and no wandering</td>
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<td>behavior, reported choosing own bedtime and</td>
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<td>going outside to get fresh air was &quot;very</td>
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<td></td>
<td>important&quot;; and received no antipsychotic,</td>
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<td></td>
<td>anti-anxiety, antidepressant or hypnotic</td>
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<td>medications.</td>
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<td></td>
<td>Medical record review of nurses' notes, social</td>
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<td>services notes, activity notes, physician's orders</td>
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<td></td>
<td>and the physician's progress notes dated from</td>
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<td>June 1, 2012 through June 14, 2013 revealed no</td>
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<td>documentation related to aggressive, verbal or</td>
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<td></td>
<td>physical behaviors or alterations with other</td>
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<td>residents or staff and no documentation related to</td>
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<td>a need for medical treatment related to</td>
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<td></td>
<td>behaviors.</td>
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<td></td>
<td>Medical record review of a social services note</td>
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<tr>
<td></td>
<td>dated March 5, 2013 revealed, &quot;...complains of</td>
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</table>
**Name of Provider or Supplier:** Greystone Health Care Center  
**Street Address, City, State, Zip Code:** 181 Dunlap Road, Blountville, TN 37617

<table>
<thead>
<tr>
<th>ID (X4)</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>ID (X2)</th>
<th>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 (X5)</th>
</tr>
</thead>
</table>
| F 202   |        |     | Continued From page 2 restlessness @ (at) night...Continues to perform activity of choice as...wishes... Receives volunteer visits at least weekly from Ombudsman..." Medical record review of the care plan updated May 2013 revealed, "...Impaired thought processes related to advanced Dementia...Resident establishes own goals...Encourage to make own decisions at own level of ability...Monitor for changes in cognition, mood, behavior... (signs of) Depression...Activity: walking outside, sitting on porch, chewing tobacco...Monitor for Anxiety/Insomnia and report..." Continued review revealed "...Insomnia...Sleep pattern disturbance RT (related to) Insomnia...Provide consistent care routine at night..." Continued review revealed, "...Sensory-perceptual alteration: Hearing RT hearing loss...Speak in a well-modulated tone. Use appropriate gestures..." Medical record review of a social services progress note dated May 20, 2013 revealed "...suffers impaired memory d/t (due to) Dementia...", had trouble staying asleep and "...walks as...pleases, knows...where wants to go..." Continued review revealed the resident was emotionally stable; exhibited good coping skills; and had accepted placement in the facility. Continued review revealed "...generally pleasant...Does become agitated at times, i.e. with unwanted food/meds...Expected to stay long term..." Medical record review of the physician's monthly recapitulation orders dated June 1-30, 2013 revealed the resident received no scheduled medications except for an antibiotic (Clindamycin) which was ordered June 19, 2013 to treat a
F 202 Continued From page 3

Possible spider bite on the right lower leg.

Medical record review of a nurse's note dated June 15, 2013 at 8:40 p.m. revealed, "Resident in room yelling @ (at) roommate/trying to hit roommate. Nurse stood between two residents. (Physician) called for order to send to (hospital) ER (Emergency Room) for psych (psychiatric) eval (evaluation) Roommate immediately moved out of room to another area. Resident laid (laid) in bed & (and) covered up..."

Medical record review revealed the resident was transported to the hospital on June 15, 2013 at 9:20 p.m.

Medical record review of a nurse's note dated June 16, 2013 at 12:05 a.m. revealed a Registered Nurse from the hospital called and notified the facility the resident "...is (no) harm to anyone..."

Medical record review of the hospital Emergency Room report dated June 16, 2013 at 1:30 a.m. revealed "...(Psychiatric staff) came and evaluated the patient and felt that...was not a risk to self or others and would be appropriate to go back to the nursing home...Disposition decision is discharge..."

Medical record review of a nurse's note dated June 16, 2013 at 2:00 a.m. revealed the resident returned to the facility.

Medical record review of nurses' notes dated June 16, 2013 through June 26, 2013 revealed the resident had no further aggressive behaviors toward other residents.
Continued From page 4

Medical record review of a social services note dated June 18, 2013 revealed "...Notified that resident was to receive a 30 day discharge notice...(No) further incidents of aggression..."

Medical record review of a mental health progress note dated June 19, 2013 revealed the resident's prognosis was "good" with "...Person centered therapy...Relaxation techniques...Confrontation of inappropriate behavior...group activities...Stress/Anger management..."

Medical record review of a physician's order dated June 19, 2013 revealed, "Aricept (used for mild to moderate Alzheimer's Dementia) 5 mg (milligram) po (by mouth) q (every) hs (at bedtime)...Namenda (used for moderate to severe Alzheimer's Dementia) 5 mg po q hs x (times) 1 wk (week) then (increase) to BID (twice daily)...Ativan (used for Anxiety and Insomnia) 0.5 mg po TID (three times daily) pm (as needed)..."

Medical record review of a social services note dated June 20, 2013 revealed, "(No) further behavioral incidents..."

Medical record review of social services note dated June 21, 2013 revealed, "...Resident had continued to enjoy own activity. Monitored for behavioral issues...None to note..."

Medical record review of a social services note dated June 26, 2013 revealed the resident was transferred to another facility on June 26, 2013.

Review of an "Involuntary Discharge" notice dated June 18, 2013 revealed "...Please accept this notice that due to the reasons listed below,
Continued From page 5
(resident) will be discharged from (facility) on or about Thursday, July 18, 2013...due to the following facts: "The safety of the individuals in the facility is endangered...The health of individuals in the facility would otherwise be endangered..."

Interview on August 15, 2013 at 12:10 p.m. in the family room with the Director of Nursing (DON-employed in July 2013) confirmed the DON had reviewed the resident's clinical record and confirmed no documentation by the physician related to the health and safety of other residents and the need to discharge the resident involuntarily from the facility.

Telephone interview on August 20, 2013 at 9:30 a.m. with the Ombudsman revealed the resident was "not doing well and keeps asking to go home (back to the facility from which he was discharged)."

Telephone interview on September 5, 2013 at 10:05 a.m. with the volunteer Ombudsman who continued to visit the resident at the current facility revealed the resident "keeps asking to go back to the facility to see his sister (who still resides in the facility)." Continued interview revealed the volunteer Ombudsman told the resident his sister would not know him if he did go visit her. Continued interview revealed the resident stated, "I just want to go see her." Continued interview revealed the Ombudsman had discussed with the family the possibility of moving the sister to the same facility with the resident. The family refused because the distance was too far for the family to visit (53 miles round trip between facilities).
<table>
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<th>F 202</th>
<th>Continued From page 6</th>
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<tbody>
<tr>
<td>Telephone interview on September 5, 2013 at 1:30 p.m. with the volunteer Ombudsman revealed the Ombudsman had visited the resident at least once during the weeks since the discharge and had also visited the resident on Sundays (August 4, 11, and 18, 2013) in addition to the weekly visits. The Ombudsman reported the last time he saw the resident was Tuesday, September 3, 2013. The Ombudsman stated, &quot;Every time I go he's asking to go back to Greystone.&quot; The Ombudsman stated, &quot;I tried to make him feel a little better&quot; about the current facility. The resident responded by stating, &quot;Yeah, but I can't see (sister named).&quot;</td>
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<thead>
<tr>
<th>F 203</th>
<th>483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE</th>
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<tbody>
<tr>
<td>Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.</td>
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<thead>
<tr>
<th>F 203</th>
<th>483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE</th>
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<tbody>
<tr>
<td>Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</td>
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<p>| Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered. |</p>
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<th>F 203</th>
<th>Continued From page 7</th>
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<td>under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</td>
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<td>The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with development disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of hospital records, review of a thirty-day letter of involuntary discharge and interview, the facility failed to ensure one resident (#26) was provided a thirty-day involuntary discharge notice of thirty-three residents reviewed. The facility's</td>
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</table>
F 203  Continued From page 8
failure resulted in harm for resident #26 causing emotional and mental distress.

Resident #26 was admitted to the facility on January 25, 2007 (six years in facility) with diagnoses including Prostatitis, Dementia, Psychosis, Anxiety, history of Cerebrovascular Accident (Stroke) Benign Prostatic Hypertrophy and Hearing Loss.

Medical record review of the annual Minimum Data Set (MDS) dated May 19, 2013 revealed the resident had short-term memory impairment and modified independence with daily decision-making (difficulty in new situations only) and usually understood (missed some part/intent of the message but comprehended most conversation).

Medical record review of nurses' notes, social services notes, activity notes, physician's orders and the physician's progress notes dated from June 1, 2012 through June 14, 2013 revealed no documentation related to aggressive, verbal or physical behaviors or altercations with other residents or staff and no documentation related to a need for medical treatment related to behaviors.

Medical record review of the care plan updated May 2013 revealed, "...Impaired thought processes related to advanced Dementia...Resident establishes own goals...Encourage to make own decisions at own level of ability...Monitor for changes in cognition, mood, behavior..."

Medical record review of a social services progress note dated May 20, 2013 revealed
F 203 Continued From page 9
"...suffers impaired memory d/t (due to) Dementia..."

Medical record review of a nurse’s note dated June 15, 2013 at 8:40 p.m. revealed, “Resident in room yelling @ (at) roommate/trying to hit roommate. Nurse stood between two residents. (Physician) called for order to send to (hospital) ER (Emergency Room) for psych (psychiatric) eval (evaluation)...Roommate immediately moved out of room to another area...Resident layed (laid) in bed & (and) covered up...”

Medical record review revealed the resident was transported to the hospital on June 15, 2013 at 9:20 p.m.

Medical record review of a nurse's note dated June 16, 2013 at 12:05 a.m. revealed a Registered Nurse from the hospital called and notified the facility the resident "...is (no) harm to anyone..."

Medical record review of the hospital Emergency Room report dated June 16, 2013 at 1:30 a.m. revealed "...(Psychiatric staff) came and evaluated the patient and felt that...was not a risk to self or others and would be appropriate to go back to the nursing home...Disposition decision is discharge..."

Medical record review of a nurse’s note dated June 16, 2013 at 2:00 a.m. revealed the resident returned to the facility.

Medical record review of nurses’ notes dated June 16, 2013 through June 26, 2013 revealed the resident had no further aggressive behaviors toward other residents.
**F 203** Continued From page 10

Medical record review of a social services note dated June 18, 2013 revealed "...Notified that resident was to receive a 30 day discharge notice. Notice was hand delivered..."

Medical record review of a mental health progress note dated June 19, 2013 revealed the resident's prognosis was "good" with "...Person centered therapy...Relaxation techniques...Confrontation of inappropriate behavior...group activities...Stress/Anxiety management..."

Medical record review of a physician's order dated June 19, 2013 revealed, "Aricept (used for mild to moderate Alzheimer's Dementia) 5 mg (milligram) po (by mouth) q (every) hs (at bedtime)...Namenda (used for moderate to severe Alzheimer's Dementia) 5 mg po q hs x (times) 1 wk (week) then (increase) to BID (twice daily)...Ativan (used for Anxiety and Insomnia) 0.5 mg po TID (three times daily) prn (as needed)..."

Medical record review of a social services note dated June 20, 2013 revealed, "(No) further behavioral incidents..."

Medical record review of social services note dated June 21, 2013 revealed, "Spoke (with resident's) emergency contact re: 30 day discharge (and) acceptance of resident by (two named facilities)...Resident had continued to enjoy own activity. Monitored for behavioral issues...None to note..."

Medical record review of a social services note dated June 26, 2013 revealed the resident was transferred to another facility.
Review of an "Involuntary Discharge" notice addressed to the resident and dated June 18, 2013 revealed "...Please accept this notice that due to the reasons listed below, (resident) will be discharged from (facility) on or about Thursday, July 18, 2013...due to the following facts: "The safety of the individuals in the facility is endangered...The health of individuals in the facility would otherwise be endangered..."

Interview on August 6, 2013 at 10:40 a.m. in the family room with the volunteer Ombudsman revealed the volunteer Ombudsman visited the resident on a weekly basis. Continued interview revealed the facility "handed" a 30-day notice of involuntary discharge to the resident. Continued interview revealed the resident could not read and gave the letter to the volunteer Ombudsman (date not identified). Continued interview revealed the facility discharged the resident "within a week" of giving the discharge notice to the resident.

Interview on August 6, 2013 at 1:10 p.m. in the family room with the Social Worker revealed the facility's "...legal department decided (resident) needed to go..." Continued interview revealed the Social Worker delivered the 30-day discharge to the resident; had no knowledge of whether the resident was able to read; and did not read the discharge notice to the resident. Continued interview revealed the Social Worker reported no recall of discussing the appeal rights with the resident. Continued interview confirmed the resident was not given thirty days to file an appeal and confirmed the facility was "actively" seeking placement in another facility immediately after the discharge notice was issued.
Continued From page 12
Interview on August 15, 2013 at 11:50 a.m. in the family room with the Administrator revealed a discharge notice was sent Certified mail to "a family member" (unspecified) which was returned to the facility and the discharge notice was sent to the Ombudsman's. Continued interview revealed the facility had "safety" concerns with the resident (non included in the 30-day involuntary discharge notice) and confirmed, "afraid he might get hurt..."
Continued interview confirmed the resident was not given thirty days to file an appeal.

Telephone interview on August 19, 2013 at 3:30 p.m. with the Social Worker confirmed the Social Worker had talked with a family member (named nephew) on June 21, 2013 (5 days prior to the resident's discharge), and the family had no understanding of why and was "upset" the resident was being discharged to another facility. Continued interview confirmed the Social Worker did not discuss the resident's appeal rights with the family. Continued interview confirmed the Social Worker "learned after the discharge" that the resident could not read. Continued interview confirmed, at the time of discharge, the resident had no clear understanding he was being permanently discharged from the facility to another nursing home.

Telephone interview on August 19, 2013 at 3:50 p.m. with the nephew (identified by the Social Worker as noted above) revealed, "They picked him up and hauled him off like a bag of garbage." Continued interview revealed the facility refused to give the family any information related to the reason for discharge. Continued interview revealed no family member had received the 30-day notice of involuntary discharge.
Continued interview confirmed the resident "never
F 203 Continued From page 13
went to school a day in his life...could not read...

Telephone interview on August 20, 2013 at 9:30 a.m. with the Long-Term Care Ombudsman confirmed the Ombudsman received the 30-day notice of discharge from the volunteer Ombudsman who visited the resident. Continued interview confirmed a meeting was held with the family, the facility's administrative staff and the Ombudsman, after the resident was discharged, to determine why the resident was discharged and was not given his appeal rights. Continued interview confirmed, during the meeting, the only reason given by the administrative staff for the discharge was the "safety of others."

Telephone interview on August 20, 2013 at 9:30 a.m. with the Ombudsman revealed the resident was "not doing well and keeps asking to go home (back to the facility from which he was discharged)."

Telephone interview on September 5, 2013 at 10:05 a.m. with the volunteer Ombudsman who continued to visit the resident at the current facility revealed the resident "keeps asking to go back to the facility to see his sister (who still resides in the facility)." Continued interview revealed the volunteer Ombudsman told the resident his sister would not know him if he did go visit her. Continued interview revealed the resident stated, "I just want to go see her." Continued interview revealed the Ombudsman had discussed with the family the possibility of moving the sister to the same facility with the resident. The family refused because the distance was too far for the family to visit (53 miles round trip between facilities).
Continued From page 14
Telephone interview on September 5, 2013 at 1:30 p.m. with the volunteer Ombudsman revealed the Ombudsman had visited the resident at least once during the weeks since the discharge and had also visited the resident on Sundays (August 4, 11, and 18, 2013) in addition to the weekly visits. The Ombudsman reported the last time he saw the resident was Tuesday, September 3, 2013. The Ombudsman stated, "Every time I go he's asking to go back to Greystone." The Ombudsman stated, "I tried to make him feel a little better" about the current facility. The resident responded by stating, "Yeah, but I can't see (sister named)."

Refer to F-202
C/O #32298
F 204
SS=G
483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG
A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, review of hospital records, review of a thirty-day letter of involuntary discharge and interview, the facility failed to provide sufficient preparation and orientation for an involuntary discharge of one resident (#26) of thirty-three residents reviewed. The facility's failure resulted in harm for resident #26 causing emotional and mental distress.

F 204 Preparation for safe and orderly transfer
Resident #26 no longer resides in the facility.

Admission/Discharge files were reviewed to identify any residents who were involuntarily discharged/transferred since June 26, 2013 and whether they were provided sufficient preparation and orientation for a discharge/transfer. No residents were identified as involuntarily discharged or transferred.

A review of the regulatory requirement of F204 was completed by the Administrator and Director of Nursing on 8/17/13. Facility administrative staff/department manager/Social Workers will be re-educated by 9/23/13 on provision of sufficient preparation and orientation for an involuntary discharge/transfer.

The DON/Designee will verify on all involuntary discharges that physician orders are in place, notice is properly given and communicated to the resident/responsible party and transfer preparation is complete and in place.

The Administrator will audit twice monthly that documentation is complete.

Audit results will be reviewed in the monthly QA&A meeting with revision to the plan as deemed appropriate by the QA&A Committee.
F 204 Continued From page 15

Resident #26 was admitted to the facility on January 25, 2007 (six years in facility) with diagnoses including Prostatitis, Dementia, Psychosis, Anxiety, history of Cerebrovascular Accident (Stroke) Benign Prostatic Hypertrophy and Hearing Loss.

Medical record review of the annual Minimum Data Set (MDS) dated May 19, 2013 revealed the resident had short-term memory impairment and modified independence with daily decision-making (difficulty in new situations only); usually understood (missed some part/intent of the message but comprehended most conversation); reported trouble falling or staying asleep, or sleeping too much; was not short-tempered or easily annoyed; had no physical or verbal behavior symptoms toward others; had no rejection of care and no wandering behavior; reported choosing own bedtime and going outside to get fresh air was "very important"; was independent with bed mobility, transfer, ambulation and toileting; required supervision (oversight, encouragement or cueing) with dressing, eating, hygiene and bathing; had no limitation in range of motion; required no devices (cane, walker or wheelchair) for mobility; was continent of bowel and bladder; had no pain or history of fall; and received no antipsychotic, anti-anxiety, antidepressant or hypnotic medications.

Medical record review of nurses' notes, social services notes, activity notes, physician's orders and the physician's progress notes dated from June 1, 2012 through June 14, 2013 revealed no documentation related to aggressive, verbal or physical behaviors or allegations with other residents or staff and no documentation related to
<table>
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| F 204 | Continued From page 16
a need for medical treatment related to behaviors.

Medical record review of the care plan updated May 2013 revealed, "...Impaired thought processes related to advanced Dementia... Resident establishes own goals... Encourage to make own decisions at own level of ability... Activity: walking outside, sitting on porch, chewing tobacco... Monitor for Anxiety/Insomnia and report..." Continued review revealed "...Insomnia... Sleep pattern disturbance RT (related to) Insomnia... Provide consistent care routine at night..." Continued review revealed, "...Sensory-perceptual alteration: Hearing RT hearing loss... Speak in a well-modulated tone. Use appropriate gestures..."

Medical record review of a social services progress note dated May 20, 2013 revealed 
"...suffers impaired memory d/t (due to) Dementia... walks as... pleases, knows... where wants to go..." Continued review revealed the resident was emotionally stable; exhibited good coping skills; and had accepted placement in the facility. Continued review revealed "...Does often speak of going to Jonesboro or Iowa... generally pleasant... Does become agitated at times, i.e. with unwanted food/meds... Expected to stay long term..."

Medical record review of the physician's monthly recapitulation orders dated June 1-30, 2013 revealed the resident received no scheduled medications except for an antibiotic (Clindamycin) which was ordered June 19, 2013 for ten days to treat a possible spider bite on the right lower leg.

Medical record review of a document entitled...
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</table>
| F 204          | "Wander/Elopement Risk Evaluation" dated June 13, 2013 revealed the resident was not at risk for elopement and "Pt (Patient) walks around outside-however...stays on grounds. Verbalized (no) desire to leave facility..."

Medical record review of a nurse’s note dated June 15, 2013 at 8:40 p.m. revealed, "Resident in room yelling @ (at) roommate/trying to hit roommate. Nurse stood between two residents. (Physician) called for order to send to (hospital) ER (Emergency Room) for psych (psychiatric) eval (evaluation)...Roommate immediately moved out of room to another area...Resident layed (laid) in bed & (and) covered up..."

Medical record review revealed the resident was transported to the hospital on June 15, 2013 at 9:20 p.m.

Medical record review of a nurse's note dated June 16, 2013 at 12:05 a.m. revealed a Registered Nurse from the hospital called and notified the facility the resident "...is (no) harm to anyone..."

Medical record review of the hospital Emergency Room report dated June 16, 2013 at 1:30 a.m. revealed "Mental Status...within normal limits...states that roommate leaves the TV on and (resident) want to cut it off and got into an altercation with roommate...(Psychiatric staff) came and evaluated the patient and felt that...was not a risk to self or others and would be appropriate to go back to the nursing home..."

Medical record review of a nurse's note dated June 16, 2013 at 2:00 a.m. revealed the resident returned to the facility.
Continued From page 18

Medical record review of nurses' noted dated June 16, 2013 through June 28, 2013 revealed the resident had no further aggressive behaviors towards staff or other residents.

Medical record review of a social services note dated June 17, 2013 revealed "...Contacted resident's niece and explained that we wanted to keep all residents safe and asked permission to move resident to the 3rd floor...stated...would talk it over (with) family and let me know..."

Medical record review of a social services note dated June 18, 2013 revealed "...Notified that resident was to receive a 30-day discharge notice. Notice was hand delivered. Resident stated that he would like to go to another place... (No) further incidents of aggression..."

Medical record review of a mental health progress note dated June 19, 2013 revealed the resident's prognosis was "good" with "...Person centered therapy...Relaxation techniques...Confrontation of inappropriate behavior...group activities...Stress/Anger management..."

Medical record review of a physician's order dated June 19, 2013 revealed, "Arlact (used for mild to moderate Alzheimer's Dementia) 5 mg (milligram) po (by mouth) q (every) hs (at bedtime)...Namenda (used for moderate to severe Alzheimer's Dementia) 5 mg po q hs x (times) 1 wk (week) then (increase) to BID (twice daily)...Ativan (used for Anxiety and Insomnia) 0.5 mg po TID (three times daily) prn (as needed)..."

Medical record review of a social services note...
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<td>F 204</td>
<td></td>
<td></td>
<td>Continued From page 19 dated June 20, 2013 revealed, &quot;(No) further behavioral incidents...&quot;</td>
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<td>Medical record review of social services note dated June 21, 2013 revealed, &quot;Spoke (with resident's) emergency contact re: 30 day discharge (and) acceptance of resident by (two named facilities)...Resident has continued to enjoy own activity. Monitored for behavioral issues...None to note...&quot;</td>
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<td>Medical record review of a social services note dated June 26, 2013 revealed the resident was transferred to another facility.</td>
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<td>Review of an &quot;Involuntary Discharge&quot; notice addressed to the resident and dated June 18, 2013 revealed &quot;...Please accept this notice that due to the reasons listed below, (resident) will be discharged from (facility) on or about Thursday, July 18, 2013...due to the following facts: &quot;The safety of the individuals in the facility is endangered...The health of individuals in the facility would otherwise be endangered...On the effective date of July 18, 2013, (resident) will be transferred to your custody by ambulance, at your expense, to an appropriate facility. The locations and contact information of the facility will be given prior to discharge. You will be responsible for meeting (resident's) care needs as of the effective date. Our Social Work...and nursing staff members will help you arrange for home health services, and physician follow-up. You have the right to appeal this discharge to the State of Tennessee Department of Health...&quot; Continued review revealed a copy was given to the Interim Director of Nursing (in place at the time of the involuntary discharge), the physician and the Ombudsman. Continued review revealed</td>
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NAME OF PROVIDER OR SUPPLIER
GREYSTONE HEALTH CARE CENTER

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<tr>
<td>F 204</td>
<td>Continued From page 20 the involuntary discharge notice was signed by the Administrator.</td>
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Interview on August 6, 2013 at 10:40 a.m. in the family room with the volunteer Ombudsman revealed the volunteer Ombudsman visited the resident on a weekly basis. Continued interview revealed the resident "took care of himself...was ambulatory...talked to people for hours...was an old farmer...did everything for himself...didn't even take an Aspirin..." Continued interview revealed the resident "would sit and talk to...sister (also a resident in the facility)...about their childhood...only habit was chewing Red Man...could go outside spit...could go out front or cut back to edge of woods...would stay out all day watching the planes or helicopters fly in (facility near airport)...had deer and squirrels that came around...been doing this for at least four and one-half years." Continued interview revealed the resident was confined to an enclosed courtyard at the new facility and since the transfer; the resident's mental status had declined. Continued interview revealed the day the resident was transferred to the new facility, the resident refused to get out of the transport van. The Social Worker for the facility was contacted by the new facility and asked to "come get him out of the van."

Telephone interview on August 19, 2013 at 3:30 p.m. with the Social Worker revealed the Social Worker was reticent to discuss the resident's understanding of the discharge; however continued interview confirmed the Social Worker documented in the social services note dated June 18, 2013 that the resident stated he would like to go to another place. Continued interview revealed the Social Worker stated, "I don't know"
Continued From page 21

when asked if the resident meant he wanted to go to a different nursing home or another town. Continued interview confirmed the resident had spoken of going to "Jonesboro" (TN), Iowa or to a facility that had better food. Continued interview confirmed the resident "thought he was going to Limestone (TN) or to an apartment" at the time of discharge, and had "no clear understanding" he was being permanently discharged from the facility to another nursing home. Continued interview confirmed the day the resident was discharged to the new facility, the Social Worker was notified the resident refused to get out of the van and confirmed the Social Worker was "called to assist with getting him out of the van" and into the facility. Continued interview revealed when the Social Worker arrived at the facility the resident was outside the van but refused to enter the facility. The Social Worker stated, "We kept talking to him to try and get him to go inside... Asked him if he wanted to look at the pond. He said he did. He had done some kind of work in that area. That's how we got him to go inside the building." Continued interview revealed the Social Worker had talked with a family member (named nephew) prior to the discharge, and the family had no understanding of why and was "upset" the resident was being discharged to another facility.

Telephone interview on August 19, 2013 at 3:50 p.m. with the nephew (identified by the Social Worker as noted above) revealed, "They picked him up and hauled him off like a bag of garbage... didn't even take his clothes. If they had taken his clothes, he would have known what was happening and he wouldn't have gotten in the van to begin with." Continued interview confirmed the facility did not involve the family or
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<td>F 204</td>
<td>Continued From page 22 the resident in the planning or the preparation for the discharge. Telephone interview on August 20, 2013 at 9:30 a.m. with the Ombudsman revealed the resident was &quot;not doing well and keeps asking to go home (back to the facility from which he was discharged).&quot; Telephone interview on September 5, 2013 at 10:05 a.m. with the volunteer Ombudsman who continued to visit the resident at the current facility revealed the resident &quot;keeps asking to go back to the facility to see his sister (who still resides in the facility).&quot; Continued interview revealed the volunteer Ombudsman told the resident his sister would not know him if he did go visit her. Continued interview revealed the resident stated, &quot;I just want to go see her.&quot; Continued interview revealed the Ombudsman had discussed with the family the possibility of moving the sister to the same facility with the resident. The family refused because the distance was too far for the family to visit (53 miles round trip between facilities). Telephone interview on September 5, 2013 at 1:30 p.m. with the volunteer Ombudsman revealed the Ombudsman had visited the resident at least once during the weeks since the discharge and had also visited the resident on Sundays (August 4, 11, and 18, 2013) in addition to the weekly visits. The Ombudsman reported the last time he saw the resident was Tuesday, September 3, 2013. The Ombudsman stated, &quot;Every time I go he's asking to go back to Greystone.&quot; The Ombudsman stated, &quot;I tried to make him feel a little better&quot; about the current facility. The resident responded by stating,</td>
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F 204 Continued From page 23
"Yeah, but I can't see (sister named)."

Refer to F-202
Refer to F-203

C/O #32298

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 by:
Based on medical record review, observation and interview, the facility failed to follow physician's orders for dietary restrictions for one (#22) of thirty-three residents reviewed.

The findings included:

Resident #22 was admitted to the facility on February 11, 2013 with diagnoses including Multiple Sclerosis, Hypertension, Chronic Pain and Osteoporosis.

Medical record review of the quarterly Minimum Data Set (MDS) dated June 13, 2013 revealed the resident scored 14/15 on the Brief Interview for Mental Status (BIMs) with no cognitive impairment; had no behavior symptoms; and was totally dependent on staff for all activities of daily living (ADL).

Medical record review of the document entitled "Resident Admission Record" revealed the resident was allergic to fish.

F 204 Resident #22 has not received any fish on his meal trays.
Alert and oriented residents were interviewed by 9/17/13 to ascertain whether they had received food/fluids to which they are allergic – none were identified. Dietary staff and CNAs were interviewed by the DON to ascertain whether current residents had received on their trays food/fluids to which they are allergic – none were identified.

F 281 Food allergies for current residents will be reviewed by the DON and Dietary Manager by 9/23/13. Tray cards will be checked to verify food/fluid allergies were identified on the tray cards. Dietary staff will be re-educated by the Dietary Manager by 9/23/13 regarding checking the trays prior to serving them for items to which the resident might be allergic. Administrative staff and nursing staff will be re-educated by the SDC by 9/23/13 regarding checking tray contents against the tray cards prior to serving them for items to which the resident might be allergic.

The Dietary Manager will audit that trays are checked against the tray card for allergies prior to leaving the kitchen. Audits will be completed 3 times weekly for 2 weeks, then twice weekly for 2 weeks, then weekly for 4 weeks and then monthly.

The DON/Designee will audit that trays are checked against the tray card for allergies prior to serving to the resident. Audits will be completed 3 times weekly for 2 weeks, then twice weekly for 2 weeks, then weekly for 4 weeks and then monthly.

Audit results will be reviewed in the monthly QA&A meeting with revision to the plan as deemed appropriate by the QA&A Committee.
continued from page 24

Medical record review of the nutritional evaluation dated February 11, 2013 revealed the resident was allergic to fish.

Medical record review of the physician's history and physical dated February 12, 2013 revealed the resident was allergic to fish.

Medical record review of the physician's monthly orders dated August 1-31, 2013 revealed the resident was allergic to "Fish products."

Review of the meal ticket dated August 2, 2013 revealed, "...no fish...Allergy: All fish..."

Interview on August 15, 2013 at 8:55 a.m. in the family room with the Dietary Manager confirmed the resident was last served fish on August 2, 2013. Continued interview confirmed, "It was an accident."

Observation and interview with the resident on August 15, 2013 at 9:25 a.m. on the main hallway confirmed the resident had an allergy to and had "burning in the mouth" if fish was eaten. Continued interview confirmed the resident had recently been served fish (could not recall the date) and did not eat it.

C/O #32066, #32397

F 327 SUFFICIENT FLUID TO MAINTAIN HYDRATION

The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.

F 327 F327 Sufficient fluids to maintain hydration

Resident #10 has received 2 cups of apple juice and a diet beverage of choice.

Current residents trays were reviewed by the Dietary Manager for provision of ordered fluids. 

Dietary staff were re-educated by the Dietary Manager by 9/22/13 regarding verifying that ordered fluids are on trays prior to trays leaving the kitchen.

The Dietary Manager will audit that ordered fluids are on trays prior to leaving the kitchen. Audits will be completed 3 times weekly for 2 weeks, then twice weekly for 2 weeks, then weekly for 4 weeks and then monthly.

Audits results will be reviewed in the monthly QA &A meeting with revision to the plan as deemed appropriate by the QA &A Committee.
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<td>F 327</td>
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This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation and interview, the facility failed to ensure adequate fluids were provided for one resident (#10) at risk for dehydration of thirty-three residents reviewed.

The findings included:

Resident #10 was admitted to the facility on June 6, 2011 with diagnoses including frequent Urinary Tract Infection, Diabetes, Anemia, Dysphagia, Pneumonia, and Dementia.

Medical record review of a physician's order dated January 4, 2013 revealed, "...(#decrease) texture to puree...regular fluids...".

Medical record review of a physician's order dated January 10, 2013 revealed, "...(#increase) oral intake. Push fluids...".

Review of a Care Area Assessment (CAA) dated April 12, 2013 revealed, "...monitor nutrition/hydration status...".

Medical record review of the quarterly Minimum Data Set (MDS) dated June 11, 2013 revealed the resident scored 3/15 on the Brief Interview for Mental Status with severe cognitive impairment and was totally dependent on staff for all activities of daily living.

Medical record review of a laboratory result dated January 10, 2013 revealed an elevated BUN (Blood Urea Nitrogen—indicates kidney function by measurement of the amount of urea nitrogen in
F 327 Continued From page 26
the blood) of 30 mg (milligram)/(per)dl (deciliter) with a reference range of 7-18 mg/dl.

Medical record review of a nutritional status review dated January 14, 2013 revealed, "BUN 30...Added extra fluids..."

Medical record review of a laboratory result dated June 6, 2013 revealed an elevated BUN of 24. Continued review of the laboratory report revealed a decreased Albumin level (blood test which can indicate liver or kidney failure) of 3.1 g (gram) /dl with a reference range of 3.4-5.0 g/dl.

Review of a nutritional status review dated June 12, 2013 revealed, "...BUN (up) Alb (Albumin) (down)...Resident get(s) extra fluid on trays due to BUN (Blood Urea Nitrogen) and ALB..."

Medical record review of the care plan updated July 2013 revealed the resident was at risk for altered nutrition and dehydration. Continued review of the care plan revealed, "...Encourage fluids..."

Medical record review of the physician's recapitulation orders dated August 1-31, 2013 revealed, "...Puree texture with regular liquids...Increase oral intake..."

Observation and interview on August 5, 2013 at 12:30 p.m. revealed the resident lying in bed being fed the lunch meal by Certified Nursing Assistant (CNA) #1. Observation of the meal ticket revealed, "...Apple juice X (times) 2" and "Diet bev (beverage) of choice..." Observation revealed the only beverage served on the meal tray was one small cup apple juice. Interview with the CNA who was feeding the resident confirmed...
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<tr>
<td>F 327</td>
<td>Continued from page 27 only one small cup apple juice was served. Observation and interview in the resident's room on August 5, 2013 at 12:40 p.m. with the Dietary Manager confirmed the resident was to receive extra fluids on each meal tray and was to receive two cups apple juice and a diet beverage of choice for the lunch meal. Continue observation and interview with the Dietary Manager confirmed only one 4-ounce cup of apple juice and no other beverages had been served for the lunch meal. Interview on August 5, 2013 at 1:00 p.m. in the Dietary Manager's office with the cook who prepared the resident's lunch tray confirmed the resident &quot;should have&quot; received two cups apple juice and a diet beverage and confirmed only one 4-ounce cup of apple juice was placed on the meal tray.</td>
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<td>F 367</td>
<td>SS=D</td>
<td>C/O #32066, #32397 483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to ensure a therapeutic diet was provided for one resident (#30) of thirty-three residents reviewed. The findings included: Resident #30 was readmitted to the facility from</td>
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<td>F 327</td>
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<td>F367 Therapeutic diets Resident #30 has received sugar-free jelly with her meals. Current residents' trays were reviewed for accuracy of therapeutic dietary requirements prior to them leaving the kitchen by 9/17/13. Dietary staff will be re-educated by the Dietary Manager by 9/23/13 regarding verifying accuracy of therapeutic dietary requirements prior to trays leaving the kitchen. The Dietary Manager will audit that therapeutic dietary restrictions are followed on trays prior to leaving the kitchen. Audits will be completed 3 times weekly for 2 weeks, then twice weekly for 2 weeks, then weekly for 4 weeks and then monthly. Audit results will be reviewed in the monthly QA&amp;A meeting with revision to the plan as deemed appropriate by the QA&amp;A Committee.</td>
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Continued From page 28
the hospital on October 18, 2012 with diagnoses including Diabetes, Morbid Obesity and Chronic Obstructive Pulmonary Disease.

Medical record review of hospital discharge orders dated October 18, 2012 revealed, "Diet order...1800 cal (calorie) ADA (American Dietetic Association)..." Continued review revealed a handwritten notation "(Change) LCS (Low Concentrated Sweets)...NAS (No added salt)..."

Medical record review of a laboratory report dated May 28, 2013 revealed the blood Glucose (sugar) level was elevated at 129 mg (milligram)/dL (deciliter) with a reference range of 70-99 mg/dL.

Medical record review of a nursing assessment dated April 6, 2013 revealed, "...Type/ (and) Consistency of diet: LCS NAS Regular..."

Medical record review of a laboratory report dated June 3, 2013 revealed the blood Glucose level was elevated at 112 mg/dL.

Medical record review of the Minimum Data Set (MDS) dated June 12, 2013 revealed the resident scored 15/15 on the Brief Interview for Mental Status (BIMS) with no impairment of cognitive skills or decision-making and only required supervision and set-up assistance with eating.

Medical record review of a nutritional review dated June 12, 2013 revealed, "...Current Diet/Supplement Order...Regular LCS NAS..."

Observation and interview on August 15, 2013 at 8:35 a.m. in the resident's room revealed the resident was in bed and eating the breakfast meal. Observation of the meal ticket on the tray
F 367
Continued From page 29
revealed, "...Low/Limited conc. (concentrated)
sweets...Sugar Free Jelly..."
Observation revealed one package of non
sugar-free grape and one package of non
sugar-free mixed fruit jelly on the meal tray.
Observation of the manufacturer's printed labels
on the jelly revealed, "...Ingredients...corn syrup,
high fructose corn syrup, sugar..."

Observation and interview on August 15, 2013 at
8:40 a.m. in the resident's room with Licensed
Practical Nurse (LPN) #2 confirmed the resident
received two packages of non sugar-free jelly on
the breakfast tray.

Interview on August 15, 2013 at 8:55 a.m. with
the Dietary Manager confirmed the resident
received a NAS/LCS diet which did not include
non-sugar free jelly. Continued interview
revealed the jelly "must have gotten mixed up in
the kitchen with the sugar-free container by
mistake."

F 411 Routine or emergency dental
services in SNFS

The facility must assist residents in obtaining
routine and 24-hour emergency dental care.

A facility must provide or obtain from an outside
resource, in accordance with §483.75(h) of this
part, routine and emergency dental services to
meet the needs of each resident; may charge a
Medicare resident an additional amount for
routine and emergency dental services; must if
necessary, assist the resident in making
appointments; and by arranging for transportation

F 411
Resident #11 scheduled for the next
date the dentist will visit the facility.
That date is Oct 4.

Current residents' records were
reviewed to identify any missed dental
appointments.

Social Workers will be re-educated by
the Administrator by 9/23/13 regarding
tracking dental referrals/appointments
and validating that they have been
seen by the dentist as ordered.

An audit of dental appointments will be
completed by the 2 Social Workers
regarding tracking that dental
appointments have been made and
kept. The audit will be completed 3
times weekly for 2 weeks, then twice
weekly for 2 weeks, then weekly for 4
weeks and then monthly.

Audit results will be reviewed in the
monthly QA&A meeting with revision
to the plan as deemed appropriate by
the QA&A Committee.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**

445242

**(X2) MULTIPLE CONSTRUCTION**

A. BUILDING ______________________
B. WING ______________________

**(X3) DATE SURVEY COMPLETED**

C 09/06/2013

**NAME OF PROVIDER OR SUPPLIER**

GREYSTONE HEALTH CARE CENTER

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

181 DUNLAP ROAD
BLOUNTVILLE, TN 37617

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<td>F 411</td>
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<td>Continued From page 30 to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.</td>
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This REQUIREMENT is not met as evidenced by:

Based on medical record review, review of facility policy, observation and interview, the facility failed to ensure dental services were provided for one resident (#11) of thirty-three residents reviewed.

The findings included:

Resident #11 was admitted to the facility from the hospital on December 17, 2012 with diagnoses including Recurrent Severe Major Depressive Disorder, history of Seizure Disorder, history of Tremors, Osteopenia, Gastrointestinal Reflux Disease, Arthritis, Moderate Mental Retardation, Tracheostomy and Respiratory Failure, Dysphagia and history of Cardiopulmonary Arrest.

Medical record review of the admission Minimum Data Set (MDS) dated December 24, 2012 revealed the resident had unclear speech; was rarely or never understood and rarely or never understood others; had short and long-term memory problems with severely impaired decision-making skills; was totally dependent on staff for all activities of daily living (ADL); and had a PEG (Percutaneous Endoscopic Gastrostomy) tube for feeding.

Medical record review of the care plan dated December 30, 2012 revealed, "...Risk for alteration in mucous membranes related to dental status...dental as ordered..."
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Review of the facility's policy entitled, "Dental Services" revealed, "Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care..."

Review of the facility's policy entitled, "Dental Examination/Assessment" revealed, "Each resident shall undergo a dental assessment as needed...Upon admission and/or as need is identified the resident shall receive a dental examination...Upon conducting an oral examination, a resident needing dental services will be promptly referred to a dentist if needed..."

Observation on August 7, 2013 at 10:45 a.m. in the resident's room revealed the resident lying in bed with the eyes closed. Fibersource tube feeding was infusing via pump at 75 ml (milliliters) per hour. Observation revealed the resident's mouth was open. Observation revealed a thick, heavy, light to medium brown build-up of debris on two thirds of the upper front teeth and on the top edge of the bottom teeth. Observation revealed the upper front natural teeth were visible with a thick build-up of debris.

Observation and interview on August 7, 2013 at 10:50 a.m. in the resident's room with Licensed Practical Nurse (LPN) #1 confirmed the thick heavy build-up of debris on the teeth. Observation revealed LPN #1 applied gloves and attempted unsuccessfully to remove the debris with the gloved finger-nail. Continued interview with LPN #1 revealed, "It's always been that way." Continued interview confirmed the resident was in need of a dental consult and confirmed the resident had not been examined by a dentist since being admitted to the facility.
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Interview on August 7, 2013 at 1:15 p.m. in the family room with the Social Services Director revealed the resident was on the list for the dentist to examine January 7, 2013.

Interview on August 7, 2013 at 3:00 p.m. in the family room with the Social Services Director revealed the dentist had a verbal but not written authorization to examine the resident on January 7, 2013 and examined another resident instead of resident #11. Continued interview confirmed the resident still had not been examined by a dentist (5 months after first being scheduled in January 2013).

C/O #32066
483.70(h)
SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to maintain one bathroom shared by residents in a sanitary condition of seven residents' bathrooms observed.

The findings included:

Observation on September 3, 2013 at 10:34 a.m. of the bathroom shared by residents in rooms 325 and 327 revealed a strong, stale odor of

F 465 Safe functional, comfortable environment

The bathroom shared by residents in 325 and 327 has been cleaned and sanitized to eliminate the urine odor.

Current resident bathrooms were inspected by the Environmental Services Supervisor and cleaned/sanitized if indicated.

The Environmental Services Supervisor will re-educate the housekeeping staff by 9/23/13 regarding cleaning and sanitizing bathrooms.

The Environmental Services Supervisor will audit that bathrooms are cleaned and sanitized. Audits will be completed 3 times weekly for 2 weeks, then twice weekly for 2 weeks, then weekly for 4 weeks and then monthly.

Audit results will be reviewed in the monthly QA&A meeting with revision to the plan as deemed appropriate by the QA&A Committee.
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**F 465**

**urine in the bathroom.**

Observation and interview on September 3, 2103 at 10:35 a.m. in the bathroom shared by residents in rooms 325 and 327 with Licensed Practical Nurse (LPN)/Unit Manager confirmed the bathroom had a strong odor of urine and was in need of cleaning. Continued interview confirmed resident #33 "dribbles (urine) going to the bathroom."

Observation and interview on September 3, 2013 at 10:40 a.m. revealed a housekeeper cleaning the bathroom. Interview confirmed the bathroom had a strong odor of urine and confirmed the bathroom was in need of cleaning.

C/O #30685, #32066