C 214  1200-3-16-.02 (14) Requirements For Civil Rights Compliance

The Board for Licensing Health Care Facilities may deny, suspend, or revoke a facility's license, or otherwise discipline the facility for violations of the following requirements pursuant to T.C.A. § 68-11-207, and 68-1-113. Licensed health care facilities must comply with the following:

(14)shall maintain and make available to the OCRF for the purpose of demonstrating compliance and upon request, all data and information necessary to determine the facility's compliance with Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. Such statistical data shall include racial and ethnic data showing the extent to which minority and handicapped individuals participate in the facility's services and programs.

This Rule is not met as evidenced by:
Based on review of the facility’s forms and interview, it was determined the facility failed to conduct a self-evaluation with the use of handicapped individuals to identify any potential problem areas of the facility.

The findings included:
Review of the facility's self-evaluation form revealed no date of the evaluation, no list of handicapped individuals consulted and no documentation of issues identified.

During an interview in Room 208 on 1/21/10 at 12:20 PM, the Administrator provide the survey team with a self-evaluation form. The Administrator could not provide the survey team with a date of the evaluation, and there was no

teams will be placed on QA calendar monthly until compliance is reached. The QA committee will develop action plans and or action teams to identify existing causes of negative outcomes. An example could be re-education of staff, systems reviews, policies revisions, all depending on the findings.

C 214

1. Another self evaluation form will be completed by the Administrator and Maintenance Manager on 2-19-10 and dated with a list of handicapped individuals consulted for the evaluation on an annual basis and reported to the QA committee annually to ensure compliance.

2. same as # 1.

3. The Self Evaluation Form will be placed on the QA Committee's Calendar annually and negative findings will be submitted to the Committee.

4. Findings will be reported by the Administrator to the QA committee on an annual basis to ensure compliance. (The QA Committee consists of the Director of Nursing, ADON, RAC, RN Supervisor, Administrator,
<table>
<thead>
<tr>
<th>ID</th>
<th>PRE/TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PRE/TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETE DATE</th>
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<tbody>
<tr>
<td>214</td>
<td>C</td>
<td>Continued From page 1 list of handicapped individuals consulted for the evaluation. The facility had one side of one hall</td>
<td>214</td>
<td>C</td>
<td>Medical Director, Social Services Director, Activities Director, and others who are invited by the Committee. The QA committee will review negative findings. Any negative outcomes presented to QA and or by action teams will be placed on QA calendar monthly until compliance is reached. The QA committee will develop action plans to identify existing causes of negative outcomes.</td>
<td>01/19/2010</td>
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