Revised PO

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CIA IDENTIFICATION NUMBER:

445076

(X2) MULTIPLE CONSTRUCTION

A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED

01/28/2010

NAME OF PROVIDER OR SUPPLIER

NHC HEALTHCARE, McMinnville

STREET ADDRESS, CITY, STATE, ZIP CODE

926 OLD SMITHVILLE RD
MC MINNVILLE, TN 37110

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

F 252

SS=D

483.15(h)(1) 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 medical record review, observation, and interview, the facility failed to provide an odor-free environment for two residents (#8, #17) of twenty-five residents reviewed.

The findings included:

Resident #8 was admitted to the facility on August 12, 2002, with diagnoses including Schizophrenia, Irritable Bowel Syndrome, and Cerebrovascular Accident. Review of the Minimum Data Set (MDS) assessment dated December 3, 2009, revealed the resident has bowel and bladder incontinence daily, and required extensive assistance with personal hygiene and bathing. Review of the nurse's note dated January 5, 2010, revealed: "...Remains totally incontinent and urinates on each turn also - Has a constant dribble and foul smell to urine. Often with loose stools..." Review of the nurse's note dated January 13, 2010, revealed, "...Foul odor to urine...

Resident #17 was admitted to the facility on August 29, 2006, with diagnoses including Congestive Heart Failure, Osteoporosis, Hypertension, and Coronary Artery Disease. Medical record review of the Minimum Data Set (MDS) assessment dated December 1, 2009, revealed the resident required extensive

(08) DATE

2/4/2010

LABORATORY DIRECTORS OR PROVIDER/ SUPPLIER REPRESENTATIVE'S SIGNATURE

Administrator

2-12-2010

Patient #8 finished treatment for UTI on 12/29/2009. Placed on cranberry pills & is being followed by SilverCare Nurse Practitioner, who specializes in urinary issues. Patient #8 given new mattress on 1/26/2010 & room thoroughly cleaned. Room rounds were conducted on January 25, 27 & 28th by Department Managers (Bookkeeping, Social Work, Dietary, Housekeeping, Medical Records, Activities) to determine if other patient rooms had odor. None noted. Licensed nurses and C.N.A's inserviced by Director of Nursing on appropriate incontinence care, completed on 2/4/2010. Director of Nurses will QA #8 & #17's patient room for odor, including patient interviews weekly times 4 weeks and monthly times 3 months until substantial compliance is achieved. Department Managers (Bookkeeping, Social Work, Dietary, Housekeeping, Medical Records, Activities) to conduct room rounds throughout the remaining rooms in the healthcare center weekly for 4 weeks and monthly for 3 months or until substantial compliance is achieved. Results to be reported to the QA Committee (Administrator, Director of Nursing, Medical Director, Health Information and Assistant Director of Nursing).

Completion Date:

2/4/2010

* Revised acceptable POC *
### F 252
Continued From page 1 assistance for transfers, and was dependent on staff for personal hygiene and bathing. Continued review of the same MDS revealed the resident was incontinent of bowel and bladder daily.

Observation during the initial facility tour on January 26, 2010, at 10:20 a.m., revealed resident #8 and #17 were roommates. Observation at this time revealed a strong, stale, pungent, urine odor present in the residents' room. Observation on January 28, 2010, at 1:30 p.m., and January 27, 2010, at 8:50 a.m., revealed the strong, stale, urine odor remained. Observation on January 27, 2010, at 8:50 a.m., revealed resident #17 and resident #8 had breakfast trays on their over-bed tables. Observation revealed resident #17 complained twice about the odor stating, "It is not very appetizing trying to eat when it smells so bad."

Interview with Licensed Practical Nurse #1 on January 27, 2010 at 9:30 a.m., at the 200 hall nurses station, confirmed the room of resident #8 and #17 had a chronic foul odor; sometimes worse than others.

Interview on January 27, 2010, at 4:45 p.m., in the hall, with a family member, confirmed, "...the room has had a foul odor for sometime..." Continued interview confirmed the family member visited resident #17 on a weekly basis.

### F 312
483.25(a)(3) ACTIVITIES OF DAILY LIVING
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.
F 312 Continued From page 2

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, the facility failed to provide nail care for one (#6) of twenty-five residents reviewed.

The findings included:

Resident #6 was admitted to the facility on September 22, 2005, with diagnoses including Alzheimer's Dementia, Chronic Obstructive Pulmonary Disease, and Osteoarthritis. Medical record review of the Minimum Data Set dated November 7, 2009, revealed the resident had impaired short and long term memory and required assistance with all activities of daily living including nail care.

Observation on January 26, 2010, at 10:30 a.m., in the resident's room revealed the resident in bed receiving a bed bath from a Certified Nurse Assistant.

Observation on January 27, 2010, at 9:15 a.m., and 1:00 p.m., in the resident's room revealed the resident in bed, eyes closed, and scratching the nose with the right index fingernail. Observation revealed the fingernail was jagged and soiled with dark debris under the fingernail tip. Observation revealed the remaining fingernails on the right hand also had dark debris under the finger nails; the left hand was under the covers.

Observation on January 28, 2010, at 12:15 p.m., in the resident's room revealed the resident in bed feeding self with the right hand using the fingers and a fork; the five right hand finger nails
**NAME OF PROVIDER OR SUPPLIER**

NHC HEALTHCARE, McMinnville

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

928 OLD SMITHVILLE RD
MC MINNIVILLE, TN 37110

**DATE SURVEY COMPLETED**

01/28/2010

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### SUMMARY STATEMENT OF DEFICIENCIES

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

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
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<th>PROVIDER'S PLAN OF CORRECTION (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>DD COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 312</td>
<td>Continued From page 3</td>
<td>were soiled with dark debris; and the index finger nail was jagged; the left hand middle and thumb nails were soiled with dark debrs.</td>
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<td>F 316</td>
<td>483.26(d) URINARY INCONTINENCE</td>
<td>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</td>
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**This REQUIREMENT is not met as evidenced by:**

- Based on medical record review, facility policy review, observation, and interview, the facility failed to provide incontinence care for one incontinent resident (#17) of seven incontinent residents reviewed.

- The findings included:
  - Resident #17 was admitted to the facility on August 29, 2008, with diagnoses including Congestive Heart Failure, Osteoporosis, Hypertension, and Coronary Artery Disease.
  - Medical record review of the Minimum Data Set (MDS) assessment dated December 1, 2009,
<table>
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<tr>
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<tr>
<td>F 315</td>
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<td>Continued From page 4 revealed the resident had short term memory deficits with moderately impaired cognitive skills for daily decision making. Continued review revealed the resident required extensive assistance for transfers, was dependent on staff for personal hygiene and bathing and was incontinent of bowel and bladder.</td>
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<td>Observation on January 27, 2010, at 6:50 a.m., in the resident's room revealed Certified Nurse's Aide (CNA) #1 provided incontinence care to the resident after the resident had voided. Observation revealed CNA #1 positioned the resident on the left side, sprayed peri-wash on the resident’s buttocks, and wiped the area with a dry towel. Observation revealed CNA #1 changed the incontinence pad, repositioned the resident in a supine position, and covered the resident with the sheet and blanket.</td>
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<td>Review of the facility policy, Perineal Care, revealed, “Purpose: Perineal cleansing will be done after incontinence episodes...”</td>
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<td>Interview with CNA #1 on January 27, 2010, at 9:00 a.m., in the resident’s bathroom, confirmed the resident had not been cleansed from the front and the incontinence care was incomplete.</td>
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<td>Interview with the Corporate Nurse in the Director of Nurses office on January 28, 2010, at 8:30 a.m., confirmed the facility policy for providing incontinence care had not been followed.</td>
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