F 164 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS

The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:

Based on policy review and observation, it was determined the facility failed to ensure full visual privacy in 15 of 42 (Rooms #17, 18, 23, 26, 27, 28, 33, 35, 36, 37, 39, 41, 42, 45, and 46) resident rooms.

F 164 DISCUSSION

1. The Maintenance Director ordered curtains to ensure rooms 17, 18, 23, 26, 27, 28, 33, 35, 37, 39, 41, 42, 45, 46 8-beds and Room 36-A beds will have curtains to provide full privacy on 5/08/13. Curtains will be installed within 2 days upon arrival.

2. The Plant Manager and Housekeeping/Laundry Manager evaluated the privacy curtains for all beds on 5/8/13 to ensure the curtains enclose the bed.

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 discloseable 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 discloseable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued program participation.
The findings included:

1. Review of the facility’s “Resident Rights” policy documented, “The nursing home shall establish and implement written policies and procedures setting forth the rights of residents for the protection and preservation of dignity... Residents... rights: (a) To privacy in treatment and personal care...”

2. Observations in rooms 17, 18, 23, and 26 on 5/1/13 at 1:30 PM, revealed the privacy curtain for B-bed did not provide full visual privacy. There was no curtain at the foot of the beds to enclose the bed completely.

3. Observations in rooms 27, 28, 33, and 35 on 5/1/13 at 1:50 PM, revealed the privacy curtain for B-beds did not provide full visual privacy. There was no curtain at the foot of the beds to enclose the bed completely.

4. Observations in room 36 on 5/1/13 at 8:40 AM, revealed the privacy curtain did not provide full visual privacy for the A-bed. There was no privacy curtain at the foot of the beds to enclose the bed completely.

5. Observations in rooms 37 and 39 on 5/1/13 at 8:40 AM, revealed the privacy curtain for B-beds did not provide full visual privacy. There was no privacy curtain at the foot of the beds to enclose the bed completely.

6. Observations in room 41 on 4/30/13 at 5:00 PM, revealed the privacy curtain for B-bed did not provide full visual privacy. There was no privacy curtain at the foot of the beds to enclose the bed completely.
Grace Healthcare of Franklin

F 164 Continued From page 2

curtain at the foot of the bed to enclose the bed completely.

7. Observations in room 42 on 4/30/13 at 4:27
PM, revealed the privacy curtain for B-bed did not
provide full visual privacy. There was no curtain at
the foot of the bed to enclose the bed completely.

8. Observations in room 45 on 5/1/13 at 7:46
AM, revealed the privacy curtain for B-bed did not
provide full visual privacy. There was no privacy
curtain at the foot of the bed to enclose the bed
completely.

9. Observations in room 46 on 4/30/13 at 4:41
PM, revealed the privacy curtain for B-bed did not
provide full visual privacy. There was no privacy
curtain at the foot of the bed to enclose the bed
completely.

F 241

483.15(a) DIGNITY AND RESPECT OF
INDIVIDUALITY

The facility must promote care for residents in a
manner and in an environment that maintains or
enhances each resident’s dignity and respect in
full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:

Based on policy review and observations, it was
determined 2 of 4 certified nursing assistants
(CNA #1 and 3) failed to enhance each resident’s
dignity and respect by using terms of endearment
and referred to a resident as a feeder.

The findings included:

Director of Nursing, Medical
Director, Staff Development
Director, Social Services Director,
MDS Coordinator, Human
Resources Director, Activities
Director, Admission Coordinator,
Medical Records Director,
Rehabilitation Director, and MDS
Assistant.

1. The MDS Coordinator will review
the MDS and Plan of Care for
Resident #48 to ensure her
preferred “Courtesy Title” is
properly noted. Social Services
interviewed Resident #48 and no
adverse outcomes noted.
Certified Nursing Assistant #1 and
#3 were not individually
identified. The Staff Development
Coordinator will in-service
Certified Nursing Assistants from
5/3/13-5/24/13 on “Dignity and
Respect of Individuality” and
“Courtesy Titles”. Residents will
be addressed by Mr., Mrs., or
Miss unless other wise requested
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEC IDENTIFYING INFORMATION)</th>
<th>ID</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>
</tr>
</thead>
</table>
| F 241 | Continued From page 3 | 1. Review of the "Courtesy Titles" policy documented, "All residents at [named facility] will be addressed as Mr., Mrs., Or Miss unless otherwise requested by the resident."
2. Observations in the dining room on 4/30/13 at 11:47 AM, CNA #1 referred to residents as "feeders".
3. Observations in Resident #48's room on 4/30/13 at 11:15 AM, CNA #3 addressed Resident #48 as "sweetheart" and "darling".

F 282 | SS=s | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN
The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observations, and interviews, it was determined the facility failed to follow the care plan interventions for falls for 2 of 3 (Resident #11 and 118) sampled residents with falls of the 29 residents included in the stage 2 review.

The findings included:
1. Medical record review for Resident #11 documented an admission date of 7/6/12 with diagnoses of Cancer, Atrial Fibrillation, Hypertension, Esophageal Reflux Disease, Arthritis and Dementia. Review of the nursing admission assessment dated 7/6/12 did not

by the resident and properly addressed in their individual plan of care.

2. The Director of Nursing began observing on 5/3/13 staff interaction with residents to determine the appropriateness of "Courtesy Titles". Quarterly the MDS Coordinator and MDS Assistant will review the Plan of Care to ensure it reflects the Resident's desired "Courtesy Title". The MDS Coordinator or MDS Assistant will update any changes and notify the staff accordingly. The Unit Managers, Director of Nursing, Staff Development Coordinator, Social Service Director will monitor Staff daily and report to the Staff Development Coordinator any staff observed not addressing residents with dignity, respect and courtesy titles.

3. The Licensed nurses, dietary staff, housekeeping/laundry staff, department managers, therapy staff, maintenance and office staff will be in-serviced by the Staff Development Coordinator from 5/3/13 to 5/24/13 on "Dignity and Respect of
Continued From page 3

1. Review of the “Courtesy Titles” policy documented, “All residents at [named facility] will be addressed as Mr., Mrs., or Miss unless otherwise requested by the resident.”

2. Observations in the dining room on 4/30/13 at 11:47 AM, CNA #1 referred to residents as “feeders.”

3. Observations in Resident #48’s room on 4/30/13 at 11:15 AM, CNA #3 addressed Resident #48 as “sweetheart” and “darling”.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observations, and interviews, it was determined the facility failed to follow the care plan interventions for falls for 2 of 3 (Resident #11 and 118) sampled residents with falls of the 29 residents included in the stage 2 review.

The findings included:

1. Medical record review for Resident #11 documented an admission date of 7/6/12 with diagnoses of Cancer, Atrial Fibrillation, Hypertension, Esophageal Reflux Disease, Arthritis and Dementia. Review of the nursing admission assessment dated 7/6/12 did not
### F 241
Continued From page 3

1. Review of the "Courtesy Titles" policy documented, "All residents at [named facility] will be addressed as Mr., Mrs., or Miss unless otherwise requested by the resident."

2. Observations in the dining room on 4/30/13 at 11:47 AM, CNA #1 referred to residents as "feeders".

3. Observations in Resident #48's room on 4/30/13 at 11:15 AM, CNA #3 addressed Resident #48 as "sweetheart" and "darling".

### F 282

<table>
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<tr>
<th>SS=D</th>
<th>SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</th>
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<td>F 282</td>
<td>483.20(k)(3)(ii)</td>
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</table>

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observations, and interviews, it was determined the facility failed to follow the care plan interventions for falls for 2 of 3 (Resident #11 and 118) sampled residents with falls of the 29 residents included in the stage 2 review.

The findings included:

1. Medical record review for Resident #11 documented an admission date of 7/6/12 with diagnoses of Cancer, Atrial Fibrillation, Hypertension, Esophageal Reflux Disease, Arthritis and Dementia. Review of the nursing admission assessment dated 7/6/12 did not
**NAME OF PROVIDER OR SUPPLIER**

**GRACE HEALTHCARE OF FRANKLIN**

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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**ID PREFIX TAG** | **SUMMARY STATEMENT OF DEFICIENCIES** (Each deficiency must be preceded by full regulatory or LSC identifying information)
---|---
F 282 | Continued From page 4

address a fall risk score for the resident. Review of the Minimum Data Set (MDS) with an assessment reference date (ARD) of 7/10/12 section J1700 was coded as 1-indicating resident 311 had a fall in last month and J1700-C was coded a 1-indicating a fracture in last 6 months. The MDS with ARD of 3/21/13 section J1800 was coded as 1-indicating a fall since previous assessment and section J1900 was coded as 2-indicating 2 falls no injuries since previous assessment. Review of fall risk assessments documented the following scores: 9/6/12 - 34; 9/14/12 - 34; 12/25/12 - 36; 1/4/13 - 42; 1/14/13 - 45; 2/19/13 - 59; 3/29/13 - 14; 3/30/13 - 13 and 4/30/13 - 45; indicating the resident was at risk for falls.

Review of resident incident reports for Resident #11 documented the following:

a. 1/3/13 - "...Incident/Event Committee intervention recommendations / corrective action taken... Trial chair alarm x [times] 7 days..."

b. 2/18/13 - "...Bowel & [and] Bladder toileting pattern x 72 [symbol for hr]..."

Review of the care plan dated 4/17/13 addressed falls with interventions noted of trial chair alarm times 7 days and bowel and bladder (B&B) toileting pattern times 72 hours.

During an interview in the MDS office on 5/2/13 at 10:44 AM, the MDS nurse stated, "We've looked everywhere but haven't found anything [trial chair alarms or B&B toileting] yet, still looking..."

During an interview in the conference room on 5/2/13 at 10:53 AM, the Director of Nursing (DON) stated, "Have looked everywhere... unable

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**ID PREFIX TAG** | **PROVIDER’S PLAN OF CORRECTION** (Each corrective action should be cross-referenced to the appropriate deficiency)
---|---
F 282 | 2. MDS Coordinator and MDS Assistant audited the care plans on 100% of all residents who have fallen since 4/1/13 with interventions for Personal Alarm and Bowel / Bladder Patterning to ensure they have been completed, documented and the interventions meet the needs of the resident. If the Personal Alarm and Bowel/Bladder Patterning has not been completed the resident will be re-assessed by the interdisciplinary team per the Falls Management Protocol and identify the appropriate interventions to meet the needs of the resident. The MDS Coordinator and MDS Assistant will notify the staff of updates in the plan of care.

3. The MDS Coordinator and the MDS Assistant will educate the Certified Nursing Assistants and the Licensed Nurses when changes are made on the Care Plan regarding new fall interventions. Director of Nursing In-serviced the MDS Assistant on 5/6/13 regarding the update of clinical records for fall interventions.
F 282 Continued From page 5

to find anything where they [trail chair alarms or B&B toileting] were done..."

The facility was unable to provide documentation
the trial chair alarm was initiated for 7 days and
that the bowel and bladder toileting pattern was
initiated x 72 hours as care planned.

2. Medical record review for Resident #118,
documented an admission date of 4/2/13 with
diagnoses of Coronary Artery Disease, Diabetes, Hypertension, Cerebral Vascular
Accident, Anxiety Disorder and Depression.
Review of the MDS dated 4/18/13 documented,
"J1700 Fall History on Admission / Entry or
Reentry A 1. Yes." Review of a referral to therapy
dated 4/30/13 "Found in [on] BR [bathroom] floor
[symbol for after] attempting to self transfer from
W/C [wheelchair].... OT [Occupational Therapy] /
PT [Physical Therapy] added chair alarm to trial x
7 days ...." Review of the care plan dated 4/30/13
had intervention "Alarm x 7 days for patterning."
The facility was unable to provide documentation
that the alarm was applied as care planned.

Observations in Resident #118's room on 5/1/13
at 1:15 PM, revealed Resident #118 lying in bed
with the alarm laying on the bedside table.

Observations in Resident #118's room on 5/2/13
at 11:30 AM, revealed Resident #118's alarm was
not on the resident.

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

4. The MDS Coordinator and MDS
Assistant will audit weekly 100% of the Plans of Care for residents
that have fallen and have been identified to require a care plan
update. The MDS Coordinator
will report audit findings to the
Quality Assurance Committee for
3 months and/or 100% compliance is achieved. The
Quality Assurance Committee consists of Administrator,
Director of Nursing, Medical
Director, Staff Development
Director, Social Services Director,
MDS Coordinator, Human
Resources Director, Activities
Director, Admission Coordinator,
Medical Records Director,
Rehabilitation Director, and MDS
Assistant.
F 323  Continued From page 6
adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observations, and interviews, it was determined the facility failed to ensure assistive devices were in use to prevent falls for 2 of 3 (Residents #11 and 118) sampled resident with falls of 29 sampled residents included in the stage 2 review.

The findings included:

1. Medical record review for Resident #11 documented admission date of 7/8/12 with diagnoses of Cancer, Atrial Fibrillation, Hypertension, Esophageal Reflux Disease, Arthritis and Dementia. Review of the nursing admission assessment dated 7/6/12 did not address a fall risk score for the resident. Review of the Minimum Data Set (MDS) with an assessment reference date (ARD) of 7/10/12 section J1700 was coded as 1-indicating resident 311 had a fall in last month and J1700-C was coded a 1-indicating a fracture in last 6 months. The MDS with ARD of 3/21/13 section J1800 was coded as 1-indicating a fall since previous assessment and section J1900 was coded as 2-indicating 2 falls no injuries since previous assessment. Review of fall risk assessments documented the following scores: 9/6/12 - 34; 9/14/12 - 34; 12/25/12 - 36; 1/4/13 - 42; 1/14/13 - 45; 2/19/13 - 59; 3/29/13 - 14; 3/30/13 - 13 and 4/30/13 - 46; indicating the resident was at risk for...

The physician was notified by the nurse on 5/17/13. New orders as noted. MDS coordinator updated care plan.

Resident #11 was assessed by the nurse on 5/17/13 to determine the appropriateness of an alarm. No adverse outcomes were noted. The physician was notified by the nurse on 5/17/13. New orders as noted. MDS Coordinator updated care plan.

2. MDS Coordinator and MDS Assistant audited the care plans on 100% of all residents who have fallen since 4/1/13 with interventions for Personal Alarm and Bowel / Bladder Patterning to ensure they have been completed, documented and the interventions meet the needs of the resident. If the Personal Alarm and Bowel/Bladder Patterning has not been completed the resident will be re-assessed by the Interdisciplinary team per the Falls Management Protocol and identify the appropriate interventions to meet the needs of the resident. The MDS Coordinator and MDS Assistant will notify the staff of updates in the plan of care.
F 323 Continued From page 7

falls.

Review of resident incident reports for Resident #11 documented the following:
a. 1/3/13 - "...Incident/Event Committee intervention recommendations / corrective action taken... Trial chair alarm x [times] 7 days..."
b. 2/18/13 - "...Bowel & [and] Bladder toileting pattern x 72 [symbol for hr]..."

Review of the care plan dated 4/17/13 addressed falls with interventions noted of trial chair alarm times 7 days and bowel and bladder (B&B) toileting pattern times 72 hours.

During an interview in the MDS office on 5/2/13 at 10:44 AM, the MDS nurse stated, "We've looked everywhere but haven't found anything [trail chair alarms or B&B toileting] yet, still looking..."

During an interview in the conference room on 5/2/13 at 10:53 AM, the Director of Nursing (DON) stated, "Have looked everywhere... unable to find anything where they [trail chair alarms or B&B toileting] were done..."

The facility was unable to provide documentation the trial chair alarm was initiated for 7 days and that the bowel and bladder toileting pattern was initiated x 72 hours.

2. Medical record review for Resident #118, documented an admission date of 4/2/13 with diagnoses of Coronary Artery Disease, Diabetes, Hypertension, Cerebral Vascular Accident, Anxiety Disorder and Depression. Review of the MDS dated 4/18/13 documented, "J1700 Fall History on Admission / Entry or
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<tr>
<th>F 323</th>
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</table>

Observations in Resident #118's room on 5/1/13 at 1:15 PM, revealed Resident #118 lying in bed with the alarm laying on the bedside table.

Observations in Resident #118's room on 5/2/13 at 11:30 AM, revealed Resident #118's alarm not on the resident.

The facility was unable to provide documentation that the alarm intervention for falls was implemented.

<table>
<thead>
<tr>
<th>F 332</th>
<th>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</th>
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</table>
|       | The facility must ensure that it is free of medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review, observation, and interview, it was determined the facility failed to ensure 1 of 4 (Nurse #4) nurses administered medications with a medication error rate of less than 5 percent (%) when 2 medication errors were made out of 26 opportunities for an error, which resulted in a medication error rate of 7.69%.

<table>
<thead>
<tr>
<th>F 332</th>
<th>5/31/13</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>1. Resident #29 was examined by Physician on 5/15/13 and determined that no harm had occurred. The family was notified on May 2, 2013 by Nurse #4. No adverse reactions noted. Nurse #4 was in-serviced on 5/17/13 on the Medication Administration policy and procedure.</td>
</tr>
<tr>
<td></td>
<td>2. The Pharmacy Consultant audited a medication pass on 5/6/13. No errors noted.</td>
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</tbody>
</table>
F 332: Continued From page 9

The findings included:

Review of the facility's medication administration policy documented, "...6. The individual administering the medication must check the label THREE (3) times to verify the right medication, right dosage, right time and right method of administration before giving the medication..."

Medical record review for Resident #29 documented an administration date of 5/1/08 with diagnoses of Hemiplegia, Diabetes Mellitus, Blepharitis, Hypertension, Dysphagia and Anxiety. Review of a physician's order dated 4/2/13 documented, "...POLYETHYLENE GLYCOL... GENERIC FOR MIRALAX POWDER SEVENTEEN (17) GRAMS MIXED WITH 8OZ [ounces] WATER AND GIVEN PER TUBE Q [every] 12H [hours]... RESTASIS 0.05% EYE EMULSION ONE (1) DROP OU [both eyes] BID [two times a day] FOR DRY EYES..."

Observations in Resident #29's room on 5/2/13 at 9:27 AM, Nurse #4 administered Miralax 17 gms in 4 ounces of water (H2O) to Resident #29 per Percutaneous Endoscopy Gastrostomy (PEG) tube resulting in medication error #1. Nurse #4 instilled Restasis two (2) drops to both of Resident #29 eyes resulting in medication error #2.

During an interview outside room 22 on 5/2/13 at 10:05 AM, Nurse #4 was asked how many eye drops she administered in Resident #29's eyes. Nurse #4 stated, "I gave two (2)... should have been 1 gtt. Nurse #4 was then asked how much water did she mixed with the Miralax. Nurse #4

3. Licensed Nurses will be instructed by the Director of Nursing and/or Staff Development Coordinator from 5/24/13 on the Medication Administration policy and procedure.

4. Director of Nursing and/or Staff Development Coordinator will complete a medication pass observation of Licensed Nurses a month for 3 months and or when less than 5% error rate is achieved. The Director of Nursing will report findings to the Quality Assurance meeting which consists of Administrator, Director of Nursing, Medical Director, Staff Development Director, Social Services Director, MDS Coordinator, Human Resources Director, Activities Director, Admission Coordinator, Medical Records Director, Rehabilitation Director, and MDS Assistant.
Continued From page 10

looked at plastic drinking cup and stated, "It wasn't 8 ounces, probably about 4 ounces."

F 371

SS=E

483.35(i) FOOD PROCURE,
STORE/PREPARE SERVE - SANITARY

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based on policy review, observation, and interview, it was determined the facility failed to ensure that food was protected from sources of contamination during 2 of 2 (Lunch meal on 4/30/13 and Supper meal on 5/1/13) dining observations.

The findings included:

1. Review of the facility's "Handwashing/Hand Hygiene" policy documented, "This facility considers hand hygiene the primary means to prevent the spread of infections... 5. Employees must wash their hands for ten (10) to fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: a. Before and after direct contact with resident... b. After contact with objects (...medical equipment) in the immediate vicinity of the resident..."
**Summary Statement of Deficiencies**

2. Observations during the lunch meal in the main dining room on 4/30/13 at 11:37 AM, Registered Nurse (RN) #7 touched a resident’s back then set the meal tray up and fed the resident without washing her hands.

3. Observations during the supper meal in the main dining room on 5/1/13 from 4:45 PM to 5:15 PM, CNA #2 put a bib on a resident, opened and put straws in a tray of glasses bare handed. CNA #2’s left hand touched the cart containing the drinks as she poured water and took glasses to residents, she picked up more bibs and placed them on 5 residents, she dropped one of the bibs and picked it up from the floor and placed it on a table, she delivered more drinks to residents and then washed her hands. CNA #2 was then observed to push the drink cart to the middle of room, she opened straws and put the straws in several glasses, poured drinks and delivered to residents, she touched the back of a wheelchair, poured and delivered more drinks, patted a resident’s hands, placed straws in glasses and delivered drinks to residents. CNA #2 touched her glasses and forehead, adjusted a bib on a resident, poured and delivered more drinks, dropped ice on the floor and picked it up and gathered trash and put it in the trash can and washed her hands. CNA #2 was then observed to roll the drink cart, touched her glasses again and continued to deliver sippy cups and then trays to residents.

4. Dietary Manager and/or Director of Nursing will complete 15 random dining observations for 3 months or until 100% compliance is achieved. Findings will be reported to the Quality Assurance committee which consists of Administrator, Director of Nursing, Medical Director, Staff Development Director, Social Services Director, MDS Coordinator, Human Resources Director, Activities Director, Admission Coordinator, Medical Records Director, Rehabilitation Director, and MDS Assistant.

**Observations during the supper meal in the main dining room on 5/1/13 at 5:20 PM, RN #5 pick up and move a chair over to a resident where she sat down and started feeding the resident without**
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)</th>
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<tbody>
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<td>F 371</td>
<td></td>
<td></td>
<td>Continued From page 12 washing her hands.</td>
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<td>4. During an interview in the conference room on 5/2/13 at 2:00 PM, the Director of Nursing stated,</td>
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<td>&quot;If they [staff] touch anything that the resident has handed or touch the resident they [staff] should</td>
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<td>wash their hands. They [staff] should wash their hands between resident contact.&quot;</td>
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<tr>
<td>F 502</td>
<td></td>
<td></td>
<td>The resident #82 was assessed by their physician on 5/2/13. The family notified was notified on</td>
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<tr>
<td>SS=0</td>
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<td>5/16/13 by RN Supervisor. No adverse outcomes were noted.</td>
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<tr>
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<td></td>
<td>1. The resident #82 was assessed by their physician on 5/2/13. The family notified was notified on</td>
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<td></td>
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<td></td>
<td>5/16/13 by RN Supervisor. No adverse outcomes were noted.</td>
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<td>2. The nurse Supervisor audited labs from 4/1/13 to confirm follow-up documentation on 5/16/13.</td>
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<td>3. Nurse #8 was in-serviced by the Director of Nursing on 5/2/13 regarding the procedure for following</td>
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<td>up on all laboratory test results.</td>
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<td>Licensed nurses were in-serviced by the Staff Development Coordinator, from 5/3/13 to 5/24/13 on new</td>
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<td>lab logs, including Coumadin logs, and the procedure for correct documentation and follow up for all</td>
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<td></td>
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<td>laboratory tests.</td>
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**SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)**

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- F 502
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c. There is a need to alter the resident's treatment significantly...

Medical record review for Resident #82 documented an admission date of 2/15/11 with diagnoses of Late Effect Hemiplegia, Late Effects Cerebral Vascular disease, History of Cerebral Vascular Accident, Depressive Disorder, Hypertension, Anemia and Hyperlipidemia. Review of the lab for Prothrombin Time and International Normalized Ration (PT/INR) dated 2/8/13 documented, "...Pt [PT] 24.8... H [high]... INR 2.35... HP [high panic]..." Review of the "Physician's Telephone Orders" dated 2/8/13 documented, "1 Hold Coumadin x [times] 3 days 2 Recheck Pt [PT] /INR on 2/11/12 [13]..." There was no documentation of the lab results for 2/11/13. Review of the "Lab Flow sheet" documented the PT/INR order with due date but no date when it was obtained, or date received, or that the physician was notified under "MD Notification". Review of the care plan dated 4/8/13 documented, "Potential for injury r/t [related to] anticoagulant therapy... risk for bruising, bleeding or injury r/t [due to] use of anticoagulant use... Obtain my labs as ordered - notify the physician of results promptly..."

During an interview in the family room on 5/2/13 at 10:20 AM, Registered Nursing Consultant was asked what they would do concerning labs for example the PT/INR. Nurse #7 stated, "As far as labs, we follow physician orders, notify him of results and follow his orders..."

During an interview in the family room on 5/2/13 at 2:05 PM, the Director of Nursing (DON) was asked what was done to keep up with labs. The
F 502

DON stated, "Nurse #7 and #8 check it... A lab log shows when drawn, what results were, and any new Dr's orders..."

During an interview at the nurses' station on 5/2/13 at 2:25 PM, Nurse #8 was asked how they kept up with when labs were to be drawn and why no one noticed the lab did not come in. Nurse #8 stated, "Lab book, shows date drawn, date received, and MD notification... I don't know..."

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 observation and interview, it was determined the facility failed to ensure that computerized medical records were readily accessible for the five state surveyors to review during the annual survey that began on 4/30/13.

The findings included:

F 502^2

F 514

1. No residents were identified as having been affected.

2. The computer in the family/conference room was accessed and made available to the surveyors on 5/2/13 at 1:00pm by the maintenance director and Administrator. The three additional computers were delivered at approximately 4:00 pm and were set up by the maintenance director on 4/29/13 at 4:15 pm. The nursing station and facility computers were accessible and available throughout the survey. The nursing station computers were operational throughout the survey and no residents were noted as having been affected. An audit of the facility and nursing station computers was completed on 5/16/13 by the maintenance director and did not reveal any issues or downtime.
The state agency survey team entered the facility on 4/30/13 at 10:15 AM to conduct the annual recertification and licensure survey. The survey team was informed upon entrance by the Regional Nurse Consultant that the facility medical records were "maintained on both computer and hard copy medical records. The hard copy medical records contained physician orders, medication administration records, and laboratory test results of the residents."

The facility Regional Nurse Consultant and Administrator took the team to the family room / conference room and the Regional Nurse Consultant informed the team that one computer was available in there for the team to use. The survey team leader requested additional computers for team use. The Administrator stated, "Will contact the home office for additional computers." Approximately 1 hour later on 4/30/13 at 11:30 AM the team was informed by the Regional Nurse Consultant that "Administration had contacted home office and that they were bringing additional computers to the facility to be available by Thursday." The survey team leader asked where the home office was and was told Chattanooga. The survey team leader explained that the team would need computers today as soon as possible to conduct the survey.

The Administrator and Minimum Data Set (MDS) nurse attempted to get the computer in the family/conference room on and assessible for team use without success. The additional computers arrived at approximately 4 to 4:30 PM on 4/30/13 and the Maintenance Director began setting them up, with difficulty getting them and
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the one computer in the family/conference room up and accessible for use. It took approximately an hour to 1 and a 1/2 hours to get the computers working. The survey team left for the day at 6:15 PM without having complete access to the computerized medical records due to assigned passwords. The facility failed to ensure that computerized medical records were readily accessible.

4. The Administrator will complete an audit of the family/conference room computer for accessibility and operation five days per week for one month and then weekly for 2 months and/or until 100% compliant. The results of the audit will be reported to the Quality Assurance Improvement Committee by the Administrator. The Quality Assurance committee consists of Administrator, Director of Nursing, Medical Director, Staff Development Director, Social Services Director, MDS Coordinator, Human Resources Director, Activities Director, Admission Coordinator, Medical Records Director, Rehabilitation Director, and MDS Assistant.