F 278
SS=D

483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED
The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to accurately assess residents for transferring rehabilitation progress for 1 of 15 (Resident #2) sampled residents reviewed of 28 residents included in the acceptable pool 4/5/12 to 4/15/12.

Plan of Correction for Somerfield at The Heritage

This Plan of Correction (POC) has been developed in compliance with State and Federal Regulation. This plan affirms Somerfield at The Heritage intent and allegation of compliance with those regulations. This POC does not constitute an admission or concession of either accuracy or factual allegation made in, or existence or scope of significance, of any cited deficiency.

F278D Assessment Accuracy/Coordination/Certified

1. Resident #2 was discharged home with home health and the medical record was closed on February 23, 2012.
2. All residents have the potential to be affected by this deficient practice. No residents were negatively impacted from these practices.
3. The Director of Nursing reinserviced and counseled the MDS Coordinator on March 28, 2012, regarding the importance of coordinating assessments and verifying accuracy before certifying for submission.
4. The Director of Nursing oversees this process to ensure compliance. The DON will conduct a 20% audit monthly of all submitted MDS for accuracy. A Regional Nurse Consultant MDS audit will be

Laboratory Director or Provider/Supplier Representative’s Signature

Director 4/5/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
**SOMERFIELD AT THE HERITAGE**

**STREET ADDRESS, CITY, STATE, ZIP CODE**
900 HERITAGE WAY
BRENTWOOD, TN 37027

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<th>(X5) COMPLETION DATE</th>
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| F 278  |             | Continued From page 1  
Stage 2 review.  
The findings included:  
Medical record review for Resident #2 documented an admission date of 1/24/12 with diagnoses of Status Post Laminectomy for Decompression of Spinal Elements, Rehabilitation, Muscle Weakness, Facetectomy, Foraminotomy, and Fusion with Insertion of Intervertebral Device, Chronic Ischemic Heart Disease, Diabetes Mellitus, Hypertension and Osteoarthritis, Review of a physician's order dated 1/24/12 documented,"...Pt [patient] to receive P.T. [physical therapy] for 5x wk [5 times a week] x 12 wks for... transfers." Review of the admission Minimum Data Set (MDS) dated 1/31/12 documented,"...Section G Functional Status... G0110... Activities of Daily Living (ADL) Assistance... B... Transfer... Self-Performance... 3. Extensive assistance... Support... 3. Two+ [plus] persons physical assist..." Review of the 30-day MDS dated 2/19/12 documented,"...G0110... ADL... B... Transfer... Self-Performance... 3. Extensive assistance... Support... 3. Extensive assistance..."  
Review of the initial PT evaluation dated 1/24/12 documented,"...PLAN OF TREATMENT FUNCTIONAL GOALS... 2. Pt will perform all transfers [symbol for with] safety concerns..." Review of the PT weekly treatment plan dated 2/19/12 documented,"...Self - Reliance... transfers... 4 [minimal assistance]..." Review of the nurses notes dated 2/8/12, 2/8/12, 2/12/12, 2/16/12, 2/17/12, and 2/19/12 documented that Resident #2 required the assistance of one person for performance of ADLs and transfers. | F 278  |             | conducted in 4 months (July 2012). These activities will be reported to the Quality Improvement Committee (Administrator, Director of Nursing, MDS Coordinator, Social Service, Activities Director, Therapy Manager, Medical Director, and Dietitian). The findings will also be utilized in determining MDS job performance. | 03/22/2012 |
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<td>F278</td>
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<td>During an interview in the PT department on 3/21/12 at 2:45 PM, the Rehabilitation (Rehab) Manager was asked if Resident #2 had made progress in her ability to transfer within the first 30 days of rehab. The Rehab Manager stated, &quot;...The resident admitted with a minimal assist (1 person) transfer ability and discharged with supervision... The MDS coordinator has access to the rehab plan and treatment information. The patient did improve with transfers or we wouldn't have recommended for her to go home...&quot;</td>
<td>F279D Develop Comprehensive Care Plans</td>
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<td>During an interview in the Director of Nursing’s (DON) office on 3/22/12 at 9:45 AM, the DON was asked if the 30-day MDS was correct. The DON confirmed that the MDS was not correct for transfer, self-performance and support.</td>
<td>1. Residents #35 and #36 comprehensive care plan for limitations in range of motion were addressed and added on March 28, 2012.</td>
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<tr>
<td>F279</td>
<td>483.20(c), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</td>
<td>2. All residents with limitations in range of motion have the potential to be affected by this deficient practice. No residents were negatively impacted from these practices.</td>
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<td>SS=d</td>
<td>A facility must use the results of the assessment to develop, review and revise the resident’s comprehensive plan of care.</td>
<td>3. The Director of Nursing oversaw the MDS Coordinator on March 28, 2012, on the importance of developing a comprehensive care plan for residents that have limitations in range of motion. The process for reviewing MDS prior to submission was reviewed with the MDS Coordinator to assure understanding that the review requires IDT collaboration.</td>
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<td>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timelines to meet a resident’s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</td>
<td>4. The Director of Nursing oversees this process to ensure compliance. The DON will conduct a monthly audit of 100% for one quarter, and 5% thereafter residents identified on the 672 having impairment in range of motion per MDS for presence of range of motion orders in the care plan. Audit findings will be reported monthly to the Quality Improvement Committee (Administrator, Director of Nursing, MDS Coordinator, Social Service, Activities Director, Therapy Manager, Medical Director, and Dietitian).</td>
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F 279  Continued From page 3  
due to the resident's exercise of rights under §483.10, including the right to refuse treatment 
under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation and interview, it was determined that the facility 
failed to develop a comprehensive care plan for limitations in range of motion (ROM) for 2 of 15 
(Residents #35 and 36) sampled residents of the 28 residents included in the Stage 2 review.

The findings included:

1. Medical record review for Resident #35 documented an admission date of 7/24/09 with 
diagnoses of Coronary Artery Bypass Graph, Osteoporosis, Congestive Heart Failure, 
Depression, Lumbar Spinal Stenosis and Left Contracture. Review of the quarterly Minimum 
Data Set (MDS) dated 12/2/11 and annual MDS dated 3/2/12 documented, "...Section G... Section 
G0400... Functional Limitation in Range of motion... A... Upper Extremity... 1...Impairment 
on one side... Section V... Care Area Assessment (CAA) Summary... 05. ADL [Activities of Daily 
Living] Functional Rehabilitation Potential... A. Care Area Triggered (box is checked)... B... 
Addressed in Care Plan (box is blank)..." Review of the comprehensive care plan with an effective 
date of 3/11/10 and a revision date of 3/21/11 does not address ROM.

During an interview in the Director of Nursing's (DON) office on 3/21/12 at 3:20 PM, the DON 
verified that Resident #35's comprehensive care
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

**SUMMARY STATEMENT OF DEFICIENCIES**

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<td>2. Medical record review for Resident #36 documented an admission date of 6/10/09 with diagnoses of Contracture of Hand, Alzheimer's, Dementia with Behavioral Disturbances, Failure To Thrive, Dysphagia. Review of the MDS with an assessment reference date (ARD) of 9/11/11 and updated 12/10/11 section G0400-Functional Limitations in ROM was coded a 1 indicating the resident had limitations in ROM of upper extremity on one side. Review of the MDS with an ARD of 3/9/12 section G0400 was coded a 1 indicating the resident had limitation in ROM on one side/upper extremities. Review of a recertification Occupational Therapy (OT) note dated 1/9/11 documented, &quot;...Establish resident specific contracture management program for SUE's [Bilateral Upper Extremities]...&quot; Review of an interdisciplinary resident data collection form dated 6/20/11 documented, &quot;Current hand splints are least restrictive for bedtime schedule. Will recommend nsg [nursing] use palm protectors during day time.&quot;</td>
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Observations in the Sunflower dining room on 3/19/12 at 11:45 AM, revealed Resident #36 seated in a tilt in space wheelchair with both hands in a flexed position.

Observations in the Sunflower living room on 3/20/12 at 10:00 AM, revealed Resident #36 seated in a tilt in space wheelchair with both hands in a flexed position.

Observations in Resident #36's room on 3/21/12 at 8:49 AM, revealed Resident #36 seated in a tilt in space wheelchair with bilateral heel protectors.
**F 279** Continued From page 5 on both hands in a flexed position.

During an interview in the Astor lounge on 3/21/11 at 9:25 AM, the OT stated, "She [Resident #36] wears the splints during the night, can be used during the day if there's a lot of moisture in her hands or can use a wash cloth..."

During an interview in the Astor lounge on 3/21/12 at 9:40 AM, the DON verified there was no care plan addressing ROM or the use of splints.

**F 318**

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<th>SS=D</th>
<th>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</th>
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Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation and interview, it was determined the facility failed to ensure a resident with limitations in Range of Motion (ROM) received services to prevent further decrease in ROM for 1 of 3 (Resident #36) sampled residents of 28 sampled residents in the Stage 2 review.

The findings included:

Medical record review for Resident #36 documented an admission date of 6/10/09 with...

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**F 279**

F318D Increase/Prevent Decrease In Range of Motion

1. Resident #36 received range of motion to prevent a decrease in range of motion however it was not available for documentation in the touchscreen. The area for documentation was added to the EMR touchscreen to capture the services provided.

2. All residents with range of motion have the potential to be affected by this deficient practice. No residents were negatively impacted from these practices.

3. The Director of Nursing intervened the MDS Coordinator on March 28, 2012, on the importance of developing a comprehensive care plan for residents that have limitations in range of motion and to ensure that care plans are available on the facility’s EMR Touchscreen for documentation. CNA in-services will be held on April 12, 13 and 17th to educate and review provision of range of motion as part of ADL care and specifically programmed ROM for affected residents.

4. The Director of Nursing oversaw this process to ensure compliance. The Director of Nursing will conduct a monthly audit of documented ROM provided with for residents identified with impairment on the G72. Audit findings will be reported to the Quality Improvement Committee.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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| F 318         | Continued From page 6 diagnoses of Contracture of Hand, Alzheimer's, Dementia with Behavioral Disturbances, Failure To Thrive, and Dysphagia. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/11/11 and updated 12/10/11 section G0400-Functional Limitations in ROM was coded a 1 indicating the resident had limitations in ROM of upper extremity on one side. Review of the MDS with an ARD of 3/9/12 section G0400 was coded a 1 indicating the resident had limitation in ROM on one side/upper extremities. Review of a recertification Occupational Therapy (OT) note dated 1/9/11 documented, "...Establish resident specific contracture management program for [BUE's] Bilateral Upper Extremities..." Review of an interdisciplinary resident data collection form dated 6/20/11 documented, "Current hand splints are least restrictive for bedtime schedule. Will recommend nsg [nursing] use palm protectors during day time..."

Observations in the Sunflower dining room on 319/12 at 11:45 AM, revealed Resident #36 seated in a lift in space wheelchair with both hands in a flexed position.

Observations in the Sunflower living room on 3/19/12 at 4:35 PM and on 3/20/12 at 10:00 AM, revealed Resident #36 seated in a lift in space wheelchair with both hands in a flexed position.

Observations in Resident #36's room on 3/21/12 at 3:49 AM, revealed Resident #36 seated in a lift in space wheelchair with bilateral heel protectors on and both hands in a flexed position.

The facility was unable to provide documentation.
F 318 Continued From page 7 that Resident #36 was receiving ROM exercises.

F 371 SS=D 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 food was protected from sources of contamination when dietary workers #1 and #2 did not wear beard covers for 2 of 3 (3/19/12 and 3/21/12) days of the survey.

The findings included:

1. Review of the facility's "Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices" policy documented, "...12. Food service employees will be required to wear hairnets, caps, or other hair restraints to keep hair from contacting exposed food, clean equipment, and utensils..."

2. Observations in the Somerfield kitchen on 3/19/12 at 12:10 PM, revealed dietary worker #1 serving trays from the tray line with a beard and a mustache with no beard cover.

F371D Food Procure, Store/Prepare/Serve-Sanitary

1. Dietary workers #1and #2 shaved on March 21, 2012. This deficiency is being challenged through Informal Dispute Resolution.
2. All residents have the potential to be affected by this deficient practice. No residents were negatively impacted from these practices.
3. The Registered Dietitian in-serviced the dietary workers on April 13, 2012, regarding the importance of shaving facial hair or wearing a beard guard.
4. The Registered Dietitian oversees this process to ensure compliance. The Registered Dietitian or designee monitors daily for compliance. Any variances will be reported to the Quality Improvement Committee (Administrator, Director of Nursing, MDS Coordinator, Social Service, Activities Director, Therapy Manager, Medical Director, and Dietitian).
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<td>Observations on 3/19/12 at 12:10 PM, revealed dietary worker #2 entered the Somerfield kitchen, obtained a tray from the tray line, and delivered the tray to a resident in the dining room. Dietary worker #2 had a beard and a mustache with no beard cover. This was observed multiple times on 3/19/12 from 12:10 PM to 12:50 PM.</td>
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<td>3. Observations in the Somerfield kitchen on 3/21/12 at 12:10 PM, dietary worker #1 served trays and obtained temperatures from the tray line with a beard and a mustache with no beard cover.</td>
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<td>Observations in the Somerfield kitchen on 3/21/12 at 12:10 PM, dietary worker #2 obtained trays from the tray line. Dietary worker #2 had a beard and a mustache with no beard cover.</td>
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<td>4. During an interview in the Registered Dietician's office on 3/21/12 at 1:50 PM, the Registered Dietician (RD) / Dietary Manager (DM) confirmed dietary workers #1 and #2 were not wearing beard covers. The RD/DM stated, &quot;...we will start doing this [covering beard/mustaches], I will pass that on...&quot;</td>
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