F 000 INITIAL COMMENTS

Complaint investigations for complaint #s TN00031407 and 31406 were started on 4/22/13 and completed on 4/26/13 during the annual survey. F314 G was cited on complaint #TN00031407 and F157 D was cited on complaint #TN00031406.

F 157 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident’s physician; and if known, notify the resident’s legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident’s physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident’s legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the resident's care plan.

James Millford
Administrator
5-9-2013

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 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.
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<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>OBS COMPLETION DATE</th>
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<td>F 157</td>
<td>Continued From page 1 the address and phone number of the resident's legal representative or interested family member.</td>
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This REQUIREMENT is not met as evidenced by:
Complaint TN00031046

Based on policy review, medical record review and interview, it was determined the facility failed to notify the responsible party of a significant change in status for 1 of 5 (Resident #3) sampled residents.

The findings included:

Review of the facility's "Weight Loss" policy documented, "...Collaboratively notify... the family of the weight loss... The patient's family... must be notified. Document the name and date notified..."

Medical record review for Resident #3 documented an admission date of 5/6/12 with diagnoses of Cerebral Vascular Accident, Cardiac Dysrhythmia, Hypertensive Cardiovascular Disease, Weakness, Malignant Hypertension, Diabetes, Hyperlipidemia, Chronic Kidney Disease stage 1, Pulmonary Hypertension, Dementia and Expressive and Receptive Aphasia. Review of Resident #3's monthly weight record documented the resident weighed 117 pounds on 5/6/12, 117 pounds on 7/2012, 117 pounds on 9/2012, and 105 pounds on 10/2012 resulting in a 10 percent (%) weight loss in one month.

The physician's order documented the following:
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| F 157 | Continued From page 2  
- a. 10/15/12 - "Speech Therapy to treat dysphagia."  
- b. 10/16/12 - "Change diet to Pureed per speech therapy."
| F 157 | Review of Resident #3's meal intake form dated October 2012 documented the resident consumed 50 to (-) 100% of meals from 10/1/12 - 10/20/12. The meal intake form documented the resident meal consumption decreased from 10/21/12 - 10/31/12 to refused to 50% consumed.
| | There was no documentation in the medical record that the responsible party/family had been notified of the change in status of dysphagia requiring speech therapy to treat it or of the significant weight loss of 10%.
| | During an interview in the conference room on 4/23/13 at 10:40 AM, the Assistant Director of Nursing stated, "No documentation in the medical record of the responsible party being notified..."
| F 314 | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES
| F 314 | Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.
| | This REQUIREMENT is not met as evidenced by:
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

| (X1) PROVIDER/SUPPLIER/CBA IDENTIFICATION NUMBER: | 445262 |
| (X2) MULTIPLE CONSTRUCTION |  |
| A. BUILDING |  |
| B. WING |  |
| (X3) DATE SURVEY COMPLETED | C | 04/26/2013 |

**NAME OF PROVIDER OR SUPPLIER**

CUMBERLAND MANOR NURSING CENTER

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

4343 ASHLAND CITY HWY
NASHVILLE, TN 37218

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**F 314** Continued From page 3

Complaint TN00031470

Based on policy review, medical record review, observation, and interview, it was determined the facility failed to provide the necessary care and treatments to prevent the deterioration or promote healing of pressure sore for 1 of 4 (Residents #104) sampled residents reviewed with a pressure sore. The failure to provide treatments as ordered resulted in actual harm when Resident #104's pressure sore deteriorated from a stage 2 to an unstable pressure sore.

The findings included:

1. Review of facility's "Skin Care Guidelines" policy documented, "...Licensed nurses will complete a skin check, at a minimum of weekly or as ordered, signing off on the Medication or Treat Administration Record. If a wound is discovered, the nurse will assess the wound and notify the practitioner, documenting pertinent information (size, depth, drainage, odor, treatment orders...) in the medical record. Orders for wound care will be obtained and initiated at the time a wound is identified... Preventative measures must be implemented as soon as the patient is identified as high risk. All efforts should be made to make these interventions patient specific... Once a pressure ulcer is identified, an assessment must be documented in the Nurses Notes. The Nurses Notes must reflect that Physician and family were notified and what treatment / interventions were initiated... Daily wound treatment documentation must be completed on the Treatment Administration Record [TAR]..."
Continued From page 4

2. Medical record review for Resident #104 documented an admission dated of 12/23/10 with diagnoses of Hernia, Parkinson’s Disease, Coronary Artery Bypass Graft, Dementia, Depression and Psychosis related to Parkinson’s, Hypertension, Hyperlipidemia and Osteoarthritis. A physician’s order dated 12/29/12 documented, "clean open area c [with] NS [Normal Saline] apply Santyl-Collogen & [and] foam pad q [every] day til [until] healed." Nurses notes documented the following:
   a. 12/29/12 - "...Open area noted to buttock measuring 4.5x [by] 3.2x < [less than] 0.2 [centimeters], area has a hard mass noted @ [at] 5 o'clock. Dressing applied to open area @ this time... MD [Medical Doctor] aware of open area will monitor."
   b. 1/13/13 - "...MD in facility new orders implemented will monitor."

Review of the weekly wound progress notes documented the following:
   a. 12/29/12 - date of onset "12/29/12" measures "4.5x3.2x<0.2cm."
   b. 1/14/13 - "6x4.5x<0.2cm, stage 2."
   c. 1/21/13 - "6x9xUNS [unstagable]."

The wound had deteriorated to a stage 2 on 1/14/13. The wound had further deteriorated to being unstagable on 1/21/13.

The Registered Dietician (RD) assessment dated 11/30/12 documented the "resident on regular diet, gets a 2 PM snack, ice cream with lunch, and 50- [to] 100% [percent] consumed. The next RD assessment is dated 1/15/13 and documented, "resident on regular diet, has a stage 2 on L [left] buttocks, Promod 30 ml QD [every day] started on 1/14/13, consumes..."
F 314 Continued From page 5 50-75%..."

Observations in Resident #104’s room on 4/25/13 at 10:20 AM, Licensed Practical Nurse (LPN) #2 performed wound care on Resident #104. LPN #2 removed the old dressing from the left ischial area, cleaned, treated, and applied a new dressing to the wound with no infection control or technique concerns observed. The wound was approximately the size of a pencil eraser, circular and concurred with last assessed measurements of 1x1x0.8cm stage 2.

Review of the December 2012 TAR revealed no documentation of the daily treatment being done 1 of 3 (12/31/12) in December 2012. Review of the January 2013 TAR revealed no documentation of the daily treatment being done 5 of 20 days (1/5/13 through 1/8/13 and 1/10/13).

During an interview in the conference room on 4/25/13 at 7:30 AM the Director of Nursing (DON) verified the pressure sore was in house developed and stated, "[Named Resident #104]...Not sure why those treatments were missed will have to check into that and get back with you..."

During an interview on the 500 hall on 4/25/13 at 9:30 AM, LPN #1 stated, "...resident would get daily wound treatments if ordered daily."

During an interview in the conference room on 4/25/13 at 10:40 AM, the DON stated, "I have looked with a fine tooth comb and I do not find any documentation of those treatments... I lost my treatment nurse last July or August [2012], got another one, we gave her all kinds of inservice and education, she also worked with old
### F 314: Continued From page 6

Treatement nurse, to be truthful I noticed in January I had a problem with wound staging. I observed the treatment nurse and questioned her, found a problem, gave her more inservice training, rechecked her and decided to replace her, currently I still do not have a treatment nurse, the nurses are doing their own treatments. I have inservices and talked with them about documentation. I have done some chart audits and have reinserviced the nurses, and yes, I expect a daily wound treatment order to be done daily..."

The facility failed to provide wound treatments as ordered which resulted in actual harm when Resident #104's pressure sore deteriorated.