**INITIAL COMMENTS**

On March 14, 2012 an investigation of complaint #s TN00029390 and TN00029391 were completed along with the annual survey. Complaint #TN00029390 had deficiencies cited at F225 and F280. Complaint #00029381 had a deficiency cited at F309.

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property, and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported.

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**F000**

A. The care plan for Resident #S was reviewed by the Resident Care Management Director (RCMD) and was found to accurately reflect the care needs of the resident. No plan of care updated was required at this time. There are no reports of new bruising. The care plan was completely revised with significant change on 3-13-12 and reflects current status.

The care plan for Resident #11 was updated by the RCMD to reflect possible fall on April 21, 2011 and February 29, 2012 interventions were placed on falls care plan. The RCMD also reviewed the plan of care and determined that it accurately reflected the care needs of the resident with these additions.

B. All incidents of unknown origin for residents within the facility that have occurred within the previous 30 days will be reviewed by the director of nursing, assistant director of nursing, resident care management director or unit manager for accuracy and thoroughness. The incident report and investigation will be reviewed to determine if a full and appropriate investigation was completed per protocol. Those found to be deficient will have a more in-depth investigation completed to correct those deficiencies. Appropriate interventions will be put in place and updated on the

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<tr>
<th>(X4) ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>COMPLETION DATE</th>
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<tr>
<td>F 000</td>
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**SIGNATURE DIRECTOR OR PROVIDER/REPRESENTATIVE SIGN**

**TITLE**

[Signature]

4/5/12

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The findings stated above are discloseable 90 days after the date of survey 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 requisite to continued participation.
F 225 Continued From page 1

to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Intakes: TN00029390

Based on medical record review, review of incident / accident reports, observation and interview, it was determined the facility failed to thoroughly investigate an injury of unknown origin for 2 of 24 (Residents #5 and 11) sampled residents.

The findings included:

1. Medical record review for Resident #5 documented an admission date of 8/16/02 with diagnoses of Hypertension, Gastro-Esophageal Reflux Disease, Cerebral Seizure, Depression, Dysphagia and Polymyalgia Rheumatica. Review of the facility's "INCIDENT/ACCIDENT REPORT" dated 4/30/11, documented, "...hematoma to R [right] side of forehead... blue color... denies any pain... Time of incident/accident: 8:30 PM... Exact location of incident/accident: Resident's room... Incident/Injury Type: Hematoma... Cognition state prior to incident/accident: Normal... Name of Physician notified..." Review of the facility's "CHANGE OF CONDITION" form dated 4/30/11 documented, "...The problem/symptom I am calling about is: Hematoma to R forehead..."

F 225 Care Plan and the Kardex. Any deficiencies will be addressed with the staff involved.

C. The licensed staff will be educated on the protocols to follow when completing an incident report and investigation for an injury of unknown origin. Objectives will include:
   a. Methods for completion of and information to be included in the incident report
   b. Information to collect and consider when investigating an injury of this type
   c. Methods for soliciting and recording staff feedback regarding their knowledge of the circumstances of the incident
   d. Expectations for and process for implementing interventions to avoid future incidents
Continued From page 2

ASSESSMENT: (For LPNs) [Licensed Practical Nurse]... The patient appears: to OK..." The facility was unable to provide documentation that an investigation was conducted into the injury of unknown origin.

During an interview in the conference room on 3/14/12 at 7:00 PM, the Director of Nursing (DON) was asked if she could find documentation of an investigation into the injury. The DON stated, "...all I can find is the incident report... I cannot find the investigation..."

2. Medical record review for Resident #11 documented an admission date of 9/25/10 with diagnoses of Alzheimer's Disease, High Risk for Falls, Hypertension, Vascular Dementia and Osteopenia. Review of the facility's "CHANGE OF CONDITION" form dated 4/21/11 at 11:30 AM documented, "...Bruise in Rt [right] hip area & [and] Rt back side..." The facility was unable to provide documentation an investigation was conducted to determine how these injuries occurred.

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment, prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility...
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<th>F 225</th>
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| ASSESSMENT: (For LPNs) [Licensed Practical Nurse]. The patient appears to be OK." The facility was unable to provide documentation that an investigation was conducted into the injury of unknown origin.

During an interview in the conference room on 3/14/12 at 7:00 PM, the Director of Nursing (DON) was asked if she found documentation of an investigation into the injury. The DON stated, "...all I can find is the incident report... I cannot find the investigation."

2. Medical record review for Resident #11 documented an admission date of 9/25/10 with diagnoses of Alzheimer's Disease, High Risk for Falls, Hypertension, Vascular Dementia and Osteopenia. Review of the facility's "CHANGE OF CONDITION" form dated 4/21/11 at 11:30 AM documented, "...Bruise in Rt [right] hip area & [and] Rt back side." The facility was unable to provide documentation that an investigation was conducted to determine how these injuries occurred.

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<tr>
<th>F 280</th>
<th>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</th>
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</table>
| The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility

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<th>F 225</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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| that an accurate and thorough investigation has been completed and appropriate interventions have been implemented for 30 days. Additionally audits of 50% of incidents of unknown origin will continue to be completed for the following 30 days. The DON will be responsible for assuring that the results of all audits will be reported monthly to Quality Assurance and Assessment (QA&A) Committee. The QA&A committee may recommend and implement additional actions or audits based on results. Additional audits may also be conducted at the discretion of the Director of Nursing or Administrator.

| F 280 | A. The care plan for Resident #5 was reviewed by the Resident Care Management Director and was found to accurately reflect the care needs of the resident. No plan of care updated was required at this time. No new bruising has occurred in past year, care plan was completely revised with significant change on 3-13-12 and reflects current status. The care plan for Resident #11 was updated by the RCMD to reflect
F 280 Continued From page 3
for the resident, and other appropriate staff in
disciplines as determined by the resident's needs,
and, to the extent practicable, the participation of
the resident, the resident's family or the resident's
legal representative; and periodically reviewed
and revised by a team of qualified persons after
each assessment.

This REQUIREMENT is not met as evidenced by:
Intakes: TN00029390

Based on medical record review, it was
determined the facility failed to evaluate and
revise the resident care plan for injuries for 2 of
24 (Residents #5 and 11) sampled residents.

The findings included:

1. Medical record review for Resident #5
documented an admission date of 8/10/02 with
diagnoses of Hypertension, Gastro-Esophageal
Reflux Disease, Cerebral Seizure, Depression,
Dysphagia and Polymyalgia Rheumatica. Review
of the facility's "CHANGE OF CONDITION" form
dated 4/30/11 documented, "...Hematoma to R
[right] forehead..." The resident's care plan was
not revised with new interventions after this event.

2. Medical record for Resident #11 documented
an admission date of 9/25/10 with diagnoses of
Alzheimer's Disease, High Risk for Falls,
Hypertension, Vasular Dementia, and
Osteopenia. Review of the facility's "CHANGE OF
CONDITION" form dated 4/21/11 at 11:30 AM
possible fall on April 21, 2011 and
February 29, 2012 interventions were
placed on falls care plan. The RCMD
also reviewed the plan of care and
determined that it accurately reflected
the care needs of the resident with
these additions.

B. The Resident Care Management
Director, Unit Managers and Director of
Nursing or ADON reviewed all
incidents of unknown origin that have
occurred over last 30 days for current
facility residents to ensure that the
care plans are updated with current
interventions. Any discrepancies that
are found will be corrected.

C. A new procedure will be
implemented to assure future
compliance. The Director of
Nursing ADON or Unit Manager
will notify the Resident Care
Management Director and/or the
MDS staff of any new
interventions to be added to the
care plan following completion of
all investigations. The unit
managers will be educated on this
process by the DON or resident
care management director.

D. The resident care management
director, DON, ADON, unit
manager or MDS nurse will audit
100% of care plans for residents
with injuries of unknown origin for
30 days and will audit 50% of care
**NAME OF PROVIDER OR SUPPLIER**
GREENHILLS HEALTH AND REHABILITATION CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**
3939 HILLSBORO CIRCLE
NASHVILLE, TN 37215

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<thead>
<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>F 280</td>
<td>Continued From page 4 documented, &quot;...Bruise in Rt [right] hip area &amp; [and] Rt back side...&quot; Review of the facility's &quot;CHANGE OF CONDITION&quot; form dated 2/29/12 at 2:00 PM documented, &quot;...Bruise in Lt [left] arm &amp; [and] forehead...&quot; The resident's care plan was not revised with new interventions after these events.</td>
<td>F 280</td>
<td>plans for resident with injuries of unknown origin for the following 30 days to assure that interventions implemented as a result of investigations are appropriately reflected on the plan of care. The Resident Care Management Director will be responsible for assuring that audit results will be reported to the Quality Assessment &amp; Assurance (QA&amp;A) committee. The QA&amp;A committee will develop and implement additional recommendations as needed based on the information provided. Additional audits may also be done at the discretion of the Resident Care Management Director, DON or Administrator.</td>
</tr>
<tr>
<td>F 309</td>
<td>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</td>
<td>F 309</td>
<td>April 14, 2012</td>
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This REQUIREMENT is not met as evidenced by:

- Intakes: TN00029391

Based on medical record review, it was determined the facility failed to document any follow up assessment for pain or discomfort on the 11-7 shift for 1 of 24 (Resident #22) sampled residents.

The findings included:

Medical record review for Resident #22 documented an admission date of 2/10/12 with diagnosis of Hypertension, Gastroesophageal Reflux Disease, Diverticulosis and Systemic Lupus Erythematosus. Review of the nursing daily skilled summary dated 2/12/12 at 1:00 PM documented, "Resting in bed. c/o [complained of]
Continued From page 5

constipation. Res. [resident] encouraged to drink more water, res. reports not drinking enough water. Will continue to monitor." Review of the nursing daily skilled summary dated 2/12/12 at 11:15 PM documented, "At dinner hour resident c/o pain in the mid chest area immediately p [post] completing her food. I went in and talked with pt. [patient] got VS [vital signs] all were WNL [within normal limits] No swelling redness or sweating in arms face or chest. I noticed that pt [patient] takes omeprazole 2x [two times] daily I suggested that her pain was d/t [due to] indigestion. Instructed her about sitting [arrow pointing up] p dinner + [and] raised the head of her bed. Late in the shift I gave her PRN [as needed] pain med [medication]. She cont'd [continued] to c/o pain reassessed her BS [bowel sounds] were present VS still WNL upon palpation of ABD [abdomen] pt noted to have gas + c/o being constipated I treated her for constipation + passed this info [information] on to the oncoming nurse as it was around 11 pm by this time." Review of the nursing daily skilled summary dated 2/13/11 at 2:09 PM documented, "Resident c/o pain underneath left breast along c [with] SOB [shortness of breath] (10 AM) and pain radiating to her back. I took vitals and monitored her until ambulance arrived. 0 [no] diaphoretic, all vitals WNL, O2 [oxygen] 95% [percent] RA [room air] [name of doctor] ordered transfer to hospital." The facility was unable to provide documentation that the nurses on the 11-7 shift followed up on the residents condition until the resident was transferred to the hospital.

Review of the hospital discharge summary dated 2/20/12 documented, "...she was brought into the emergency room and was found to have basilar..."
**NAME OF PROVIDER OR SUPPLIER**

GREENHILLS HEALTH AND REHABILITATION CENTER

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

3539 HILLSBORO CIRCLE
NASHVILLE, TN 37216

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<td>F 309</td>
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<td>constipation. Res. [resident] encouraged to drink more water, res. reports not drinking enough water. Will continue to monitor. Review of the nursing daily skilled summary dated 2/12/12 at 11:15 PM documented, “At dinner hour resident c/o pain in the mid chest area immediately p [post] completing her food. I went in and talked with pt. [patient] got VS [vital signs] all were WNL [within normal limits] No swelling redness or sweating in arms face or chest. I noticed that pt [patient] takes omeprazole 2x [two times] daily I suggested that her pain was d/t [due to] indigestion. Instructed her about sitting [arrow pointing up] p dinner + [and] raised the head of her bed. Late in the shift I gave her PRN [as needed] pain med [medication]. She cont'd [continued] to c/o pain reassessed her BS [bowel sounds] were present VS still WNL upon palpation of ABD [abdomen] pt noted to have gas + c/o being constipated I treated her for constipation + passed this info [information] on to the oncoming nurse as it was around 11 pm by this time.” Review of the nursing daily skilled summary dated 2/13/11 at 2:00 PM documented, “Resident c/o pain underneath left breast along c [with] SOB [shortness of breath] (10 AM) and pain radiating to her back. I took vitals and monitored her until ambulance arrived. 0 [no] diaphoretic, all vitals WNL, O2 [oxygen] 95% [percent] RA [room air] [name of doctor] ordered transfer to hospital.” The facility was unable to provide documentation that the nurses on the 11-7 shift followed up on the residents condition until the resident was transferred to the hospital. Review of the hospital discharge summary dated 2/20/12 documented, “…she was brought into the emergency room and was found to have basilar</td>
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<tr>
<th>(X5) COMPLETION DATE</th>
<th>F 309</th>
<th>DON, unit manager, nurse supervisor or a qualified representative from a hospice organization partnering with the facility. April 14, 2012</th>
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</table>

D. In accordance with the MDS completion schedule, the MDS nurse, unit manager, DON or ADON will audit the pain management of residents. This will be done by completing pain assessments on residents, utilizing information available in the records and/or soliciting information about pain management during the resident interview. Any concerns will be reported to the DON or unit manager. Monitoring will occur for a minimum of 90 days. The director of nursing will be responsible for ensuring that the results of audits will be reported monthly to the Quality Assessment and Assurance (QA&A) Committee. The QA&A Committee will develop and implement recommendations as needed based on the information provided. Additional audits may also be done at the discretion of the DON or Administrator.
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<th>F 309</th>
<th>Continued From page 6</th>
<th>infiltrates, worse on the left. She was admitted to the hospital for pneumonia...</th>
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<tr>
<td>F 309</td>
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<td>April 14, 2012</td>
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</table>

**Summary Statement of Deficiencies**

*Each deficiency must be preceded by full regulatory or LSC identifying information.*

**Provider's Plan of Correction**

*Each corrective action should be cross-referenced to the appropriate deficiency.*

**Completion Date**

**Street Address, City, State, Zip Code**

3939 HILLSBORO CIRCLE

NASHVILLE, TN 37215