<table>
<thead>
<tr>
<th>F 000</th>
<th>INITIAL COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>An annual recertification survey and complaint investigation #s 28404 and 28289 were completed on August 15 - 17, 2011, at Vanco Manor Nursing and Rehabilitation Center. No deficiencies were cited related to complaint investigation #s 28404 and 28289 under 42 CFR PART 482.13, Requirements for Long Term Care Facilities.</td>
</tr>
<tr>
<td>F 280</td>
<td>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</td>
</tr>
<tr>
<td></td>
<td>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.</td>
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<td>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 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.</td>
</tr>
</tbody>
</table>

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview the facility failed to update the nursing care plan...

Any deficiency statement finding 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 patient. (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.
Continued from page 1
to reflect changes in resident status and failed to determine appropriate interventions to meet these changes for two (#12, #3); and failed to complete a quarterly interdisciplinary review of the care plan for one (#3) of twenty residents reviewed

The findings included:

Resident #12 was admitted to the facility on June 25, 2011, with diagnoses to include Congestive Heart Failure, Hypertension, Pacemaker Insertion, Cerebrovascular Accident, Benign Prostatic Hypertrophy, and Open Reduction Internal Fixation of Left Hip Fracture.

Medical record review of the Minimum Data Set dated July 15, 2011 revealed the resident was alert and oriented; required extensive assistance of one person with bathing, dressing, and toileting; required two person assistance with transfers; was occasionally incontinent of bowel and bladder.

Medical record review of fall risk assessments revealed a fall risk score of 18 on admission and 21 on June 28, 2011, with a score of 11 - 19 being moderate risk, and a score of 20+ being high risk for falls.

Medical record review of a nursing note dated June 28, 2011, revealed the resident was found on the floor between the two beds with no injury and a Physical Therapy recommendation for a toileting schedule.

Medical record review of a nursing note dated July 29, 2011, at 3:30 p.m., revealed the resident was reaching for another chair and tipped the
**Continued From page 2**

wheelchair over on top of self. Continued medical record review of a nursing note dated July 29, 2011, at 6:30 p.m., revealed the resident climbed out of bed to the floor. Medical record review revealed a recommendation from Physical Therapy for scheduled toileting. Medical record review revealed a Toileting Schedule with entries for July 29, 30, 31, August 1, 2, 2011, with a "V" in the spaces for 12 midnight, 2:00 a.m., 4:00 a.m., and 6:00 a.m. to indicate the resident voided in the toilet/urinal.

Medical record review of a nursing note dated July 30, 2011, revealed the resident was found lying on the floor on one side and the resident stated "...was trying to go to the bathroom..." Medical record review revealed a Physical Therapy recommendation for a bed sensor and body alarm.

Interview with the Assistant Director of Nursing (ADON) on August 17, 2011, at 12:30 p.m., in the 300 Hall nurses’ station, confirmed the nursing care plan had not been updated to reflect the bladder training program and had not been individualized to meet the resident's toileting needs.

Resident #3 was admitted to the facility on March 8, 2011, with diagnoses including Cerebrovascular Accident with Left Hemiparesis, Dysphagia, Diabetes, Hypertension, and Dementia.

Medical record review of the Minimum Data Set (MDS) dated June 15, 2011, revealed the resident required extensive assistance with
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Vanco Manor Nursing and Rehabilitation Center  
**Address:** 813 S Dickerson Rd, Goodlettsville, TN 37072  
**Date:** 08/17/2011

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>ID</th>
<th>Prefix Tag</th>
<th>Provider's Plan of Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 280</td>
<td></td>
<td>Medical record review of the August 2011 physician's orders revealed &quot;...Electric w/c (wheelchair) with seat belt for safety...&quot;</td>
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<td>Medical record review of a Physical Restraint Assessment dated June 16, 2011, revealed the resident was unable to self-release the self-releasing belt.</td>
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<td>Medical record review of the current Plan of Care (Care Plan) dated April 8, 2011, revealed no documentation related to the resident's need for the seat belt.</td>
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<td>Observation on August 17, 2011, at 12:20 p.m., revealed the resident seated in the electric wheelchair with a seat belt in place.</td>
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<td></td>
<td>Interview on August 17, 2011, at 2:35 p.m., with MDS Coordinator #1, in the MDS office, confirmed the Plan of Care had not been revisited to include the resident's need for the safety belt when in the electric wheelchair. Continued interview revealed the facility's interdisciplinary team was to review the resident's Plan of Care quarterly, and confirmed the Plan of Care had not been reviewed since April 8, 2011.</td>
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<tr>
<td>F 315</td>
<td>SS=D</td>
<td>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</td>
<td>F 315</td>
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<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 receives appropriate treatment and services to prevent urinary tract infections and to restore normal bladder function as possible.</td>
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</table>

**F315 483.25 (d) NO CATHETER, PREVENT UTI, RESTORE BLADDER**

**Requirement:**  
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 normal bladder function as possible.
Continued From page 4

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.

This REQUIREMENT is not met as evidenced by
Based on medical record review, observation,
facility policy review, and interview, the facility
failed to complete a bladder assessment and
develop an individualized toileting plan for two
(#13, #12) of twenty residents reviewed.

The findings included:

Resident #13 was admitted to the facility on
September 17, 2010, with diagnoses including
Atrial Fibrillation, Coronary Artery Disease,
Hypertension, and Diabetes.

Medical record review of the Minimum Data Set
(MDS) dated June 26, 2011, revealed the
following: the resident was usually understood;
was able to understand; had difficulty with
decision making in new situations only; required
extensive assistance with transfers; and had
urinary incontinence.

Medical record review of a Bladder Assessment
dated July 1, 2011, revealed the resident had
been incontinent for months and was always
incontinent. Continued review of the Bladder
Assessment revealed multiple factors to consider
related to bladder incontinence and a plan was to
be implemented to address the urinary
incontinence. Continued review of the Bladder
Assessment revealed no evidence factors related
to urinary incontinence.

Corrective Action:
1. Resident #12 and #13 have Bowel
   and Bladder Assessments completed and
   72 Hour Bowel and Bladder Records
   initiated.
2. All charts will be audited for Bowel
   and Bladder Assessments and 72 Hour
   Bowel and Bladder records initiated as
   needed. DON/ADON, Restorative
   Nurse, and/or designee will complete
   audit by 9/9/11.
3. In-service done for Admission
   Nurse, MDS Nurses, and Restorative
   Nurse on initiating and completing
   Bowel and Bladder Assessment and 72
   Hour Bowel and Bladder Record.
   Completed 8/30/11.
4. DON/ADON and designee will
   monitor with audits all new residents
   and residents started on 72 Hour
   program daily. Programs will be
   discussed at the Quarterly QA
   Committee Meeting for six months (Oct.
   20 and Jan. 19).
Completion Date: 9/9/11
F 315
Continued From page 5
to the resident's urinary incontinence were
identified and no evidence a toileting plan was
implemented to address the resident's
incontinence.

Observation on August 16, 2011, at 5:15 p.m.,
revealed the resident seated in a wheelchair, in
the dining room, feeding self.

Review of the facility's policy Bowel and Bladder
Program revealed "Each patient who is
incontinent should be identified, assessed, and
provided with individualized treatment and
services to achieve or maintain as normal
elimination function as possible..."

Interview on August 17, 2011, at 8:25 a.m., with
MDS Coordinator #1, in the conference room,
confirmed the Bladder Assessment dated July 1,
2011, was not completed, and confirmed an
individualized toileting program or bladder
retraining program had not been developed for the
resident.

Resident #12 was admitted to the facility on June
25, 2011, with diagnoses to include Congestive
Heart Failure, Hypertension, Pacemaker
Insertion, Cerebrovascular Accident, Benign
Prostatic Hypertrophy, and Open Reduction
Internal Fixation of Left Hip Fracture.

Medical record review of the Minimum Data Set
dated July 15, 2011, revealed the resident was
alert and oriented; required extensive assistance
of one person with bathing, dressing, and
toileting; required two person assistance with
transfers; was occasionally incontinent of bowel
<table>
<thead>
<tr>
<th>ID</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F315</td>
<td>Continued From page 6 and bladder; and was not on a toileting program. Medical record review of fall risk assessments revealed the resident was assessed a fall risk score of 18 on admission and 21 on June 28, 2011, with a score of 11-19 being moderate risk, and a score of 20+ being high risk for falls. Medical record review of a nursing note dated June 28, 2011, revealed the resident was found on the floor between the two beds with no injury. Continued medical record review of a Physical Therapy recommendation revealed a recommendation for a toileting schedule. Medical record review of a nursing note dated July 29, 2011, at 3:30 p.m., revealed the resident was reaching for another chair and tipped the wheelchair over on top of self. Continued medical record review of a nursing note dated July 29, 2011, at 6:30 p.m., revealed the resident climbed out of bed to the floor. Medical record review of a Physical Therapy recommendation revealed recommendation for scheduled toileting. Continued medical record review revealed a Toileting Schedule with entries for July 29, 30, 31, August 1, 2, 2011, with a “V” in the spaces for 12 midnight, 2:00 a.m., 4:00 a.m., and 6:00 a.m. to indicate the resident voided in the toilet/urinal. Medical record review of a nursing note dated July 30, 2011, revealed the resident was found lying on the floor on one side and the resident stated &quot;...was trying to go to the bathroom...&quot; Medical record review revealed the Physical Therapy recommendation after this fall was a bed sensor and body alarm.</td>
</tr>
</tbody>
</table>
F 315  Continued From page 7
Interview with the Assistant Director of Nursing (ADON) on August 17, 2011, at 12:30 p.m., in the 300 Hall nurses’ station, confirmed there was no bladder assessment completed for the resident. Continued interview with the ADON confirmed an individualized bladder training program had not been instituted for this resident.

F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accidents as possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, facility policy review, observation, and interview, the facility failed to ensure the correct technique was used for transfer of one (#4) resident resulting in a Humerous Fracture and harm for resident #4, and failed to ensure safety measures were in place for two (#6, #12) of twenty residents reviewed.

The findings included:
Resident #4 was admitted to the facility on April 3, 2009, with diagnoses including Cerebrovascular Accident with Right Sided Hemiparesis, Osteoporosis, and Hypertension.

Medical record review of a Nurses Event Note dated March 17, 2011, revealed, “...Resident c/o
### F 323

**Summary Statement of Deficiencies**

- **ID TAG**
  - F 323

- **Date Survey Completed**
  - 08/17/2011

**Providers Plan of Correction**

1. Upon hire, therapy department will address newly hired CNT’s and licensed nurses in their orientation; individually training them on above mention techniques of proper gait belt application and usage, proper transfer techniques with one and two persons, and proper hand placement techniques.
2. Facility will ensure, during annual evaluations, that all CNT’s and licensed nurses will have transfer techniques reevaluated by therapy department to ensure competency. Physical Therapy department and/or DON/ADON will conduct random audits with staff during transfers. Any infractions will dictate immediate one on one in service by DON/ADON and/or physical therapist. All results will be discussed with QA Committee. Any recommendations determined by QA Committee will be implemented for six months (Oct. 20 and Jan. 19).

**Corrective Action**

1. a. Resident #6 body alarm was applied on 8/17/11 at 5 pm.
   b. Resident #12 resident’s bed place in lowest position and mats were put down on each side of bed.
2. Audit completed on all interventions including, but not limited to, all alarms, bed position and mats. DON and ADON completed audit 8/25/11.
3. In-service Restorative CNT and all CNT’s on interventions that are in place. ADON will place interventions on CNT Care Plan and will be updated by ADON daily. Interventions that are temporary will be on 24 Hour Report.
4. DON/ADON or designee will monitor interventions daily during morning rounds everyday for two weeks, then once a week for a month and then as needed.

**Completion Date:** 8/31/11
F 323  Continued From page 9  
Elbow...Normal..."  
Review of a facility investigation summary dated March 21, 2011, revealed, "...On 3/16/2011 the resident was got up to go to a podiatrist appointment in the building. The techs used a two person lift which is indicated on the nurse aide communication sheet. The tech (CNA certified nursing assistant) #4 and CNA no longer employed at the facility) put their hands under the arms (axillary area) and behind the knee during the transfer. The resident tolerated the transfer well and expressed no complaints of pain. The resident was placed in an electric wheelchair and we practiced turns, stop and starting the wheelchair. After the resident demonstrated proper control of the wheelchair...was able to move about freely. A little while later the resident started to complain of pain in the right shoulder...asked the tech to lay...down and we honored...(request) using the same technique as above. The next day the nurse noted some redness and some edema to the upper arm...called the NP and received new orders for x-ray of the arm. On 3/17/2011 the x-ray showed no fracture or dislocations of the arm. On 3/21/2011 the resident continued to complain of pain in the right arm and the redness had turned to some bruising and spread down the elbow. Another x-ray ordered showing no fractures or dislocations of the arm. On 3/22/2011 NP ordered x-ray of humerus. The x-ray showed a transverse slightly impacted fracture the neck of the right humerus...Will in-service all techs regarding transfers and proper hand placements, will have one to one in-service with the tech that transferred the resident..."
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier Identification Number:**

<table>
<thead>
<tr>
<th>Provider/Supplier</th>
<th>Multiple Construction</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Building</td>
<td></td>
</tr>
<tr>
<td>B. Wing</td>
<td></td>
</tr>
</tbody>
</table>

**Name of Provider or Supplier:**

VANCO MANOR NURSING AND REHABILITATION CENTER

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

813 S DICKERSON RD
GOODLETTSVILLE, TN 37072

**ID Prefix Tag:**

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 323</td>
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</tbody>
</table>

**Summary Statement of Deficiencies:**

Each deficiency must be preceded by full regulatory or §6C identifying information.

**Provider's Plan of Correction:**

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

**Completion Date:**

09/17/2011

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Continued From page 10

Medical record review of an x-ray report dated March 22, 2011, revealed, "...Right Humerus...Transverse slightly impacted fracture neck of the right humerus..."

Medical record review of a physician's order dated March 22, 2011, revealed, "...Immobilize arm (right) (with) arm sling ortho consult ASAP (as soon as possible)."

Medical record review of an orthopaedic office note dated March 25, 2011, revealed, "...x-rays were...obtained and revealed a right humerus fracture. There is no known trauma...recommend nonoperative treatment with sling immobilization and pain control..."

Observation on August 16, 2011, at 10:40 a.m., revealed the resident lying in the bed with a splint on the right hand.

Interview on August 16, 2011, at 9:55 a.m., in the conference room, with the Assistant Director of Nursing, confirmed the techs were getting the resident up, lifted the resident under the arms and behind the knees.

Interview on August 16, 2011, at 9:55 a.m., in the conference room, with the Director of Nursing, confirmed positioning of the resident was difficult and required further x-rays to confirm the fracture.

Interview on August 16, 2011, at 10:15 a.m., in the conference room, with CNA #4, revealed CNA #4 and a CNA no longer employed by the facility, transferred resident #4 to the wheelchair with one CNA on each side of the resident by lifting the...
Continued from page 11

resident under the arms and under the legs.

Interview on August 16, 2011, at 10:30 a.m., with Occupational Therapist #1, in the therapy department, confirmed it is not appropriate to transfer a resident by lifting the resident under the arms.

Interview on August 16, 2011, at 10:40 a.m., with the Nurse Practitioner, at the nurse's station, confirmed the resident's bones are fragile.

Interview on August 16, 2011, at 12:30 p.m., in the conference room, with Physical Therapist #1, confirmed there are alternatives to transferring a resident such as two people locking their hands behind the resident's back and putting their arms under the resident's legs (cradle).

Interview on August 16, 2011, at 5:30 p.m., in the conference room, with the Assistant Director of Nursing, confirmed the resident's son was notified of the fracture and informed "we suspect it was done on a transfer technique."

Resident #6 was admitted to the facility on September 18, 2004, with diagnoses including Cerebrovascular Accident with Left Sided Hemiparesis, Hypertension, and Congestive Heart Failure.

Medical record review of a fall risk assessment dated April 12, 2011, revealed the resident was at moderate risk for falls.

Medical record review of the Minimum Data Set dated July 10, 2011, revealed the resident had a
F 323 Continued From page 12

history of falls.

Medical record review of the physician's recapitulation orders dated August 1, 2011, through August 31, 2011, revealed, "...Body alarm at all times..."

Observation on August 16, 2011, at 9:20 a.m., revealed the resident seated in a wheelchair, in the resident's room, without a body alarm in place.

Observation and interview on August 16, 2011, at 9:22 a.m., with LPN (Licensed Practical Nurse) #2, revealed the resident seated in a wheelchair, in the resident's room, and confirmed a body alarm was not in place.

Observation and interview on August 17, 2011, at 7:45 a.m., with LPN #3, revealed the resident lying on the bed and confirmed the body alarm was not attached to the resident.

Resident #12 was admitted to the facility on June 25, 2011, with diagnoses to include Congestive Heart Failure, Hypertension, Pacemaker Insertion, Cerebrovascular Accident, Benign Prostatic Hypertrophy, and Open Reduction Internal Fixation of Left Hip Fracture.

Medical record review of the Minimum Data Set dated July 16, 2011 revealed the resident was alert and oriented; required extensive assistance of one person with bathing, dressing, and toileting; required two person assistance with transfers; was occasionally incontinent of bowel and bladder.
F 323 Continued From page 13

Medical record review of fall risk assessments revealed a fall risk score of 18 on admission and 21 on June 28, 2011, with a score of 11-19 being moderate risk, and a score of 20+ being high risk for falls.

Medical record review of a nursing note dated June 28, 2011, revealed the resident was found on the floor between the two beds with no injury. Medical record review revealed Physical Therapy recommended a toileting schedule.

Medical record review of a nursing note dated July 29, 2011, at 3:30 p.m., revealed the resident had been reaching for another chair and tipped the wheelchair over on top of self. Medical record review of a nursing note dated July 29, 2011, at 6:30 p.m., revealed the resident climbed out of bed to the floor. Continued medical record review revealed Physical Therapy recommended scheduled toileting. Continued medical record review revealed a Toileting Schedule with entries for July 29, 30, 31, August 1, 2, 2011, with a "V" in the spaces for 12 midnight, 2:00 a.m., 4:00 a.m., and 6:00 a.m., to indicate the resident voided in the toilet/urinal. The only scheduled toileting was carried out on the 10:00 p.m. to 6:00 a.m. shift.

Medical record review of a nursing note dated July 30, 2011, revealed the resident was found lying on the floor on one side and the resident stated "...was trying to go to the bathroom..." Continued medical record review revealed the Physical Therapy recommendation after this fall had been to place a bed sensor and body alarm.
F 323 Continued From page 14

Interview with the Assistant Director of Nursing (ADON) on August 17, 2011, at 12:30 p.m., in the 300 Hall nurses' station, confirmed the resident's bed was not in a low position nor were there safety mats on the floor. Continued interview revealed the ADON was unsure why the toileting schedule was done at night when the resident's falls occurred during the evening hours. Further interview with the ADON revealed if a resident fell while trying to go to the bathroom on a particular shift, then Restorative does scheduled toileting on that shift.

F 368 483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME

Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.

There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.

The facility must offer snacks at bedtime daily.

When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if the resident group agrees to this meal span, and a nourishing snack is served.

This REQUIREMENT is not met as evidenced by:

Based on group interview with seven alert and oriented residents, facility policy review, and
### Continued From page 15

F 368

The facility failed to ensure bedtime (HS/hour of sleep) snacks were offered nightly to the residents.

The findings included:

Interview with seven alert and oriented residents on August 16, 2011, from 2:00 p.m., until 3:10 p.m., revealed the residents were not offered bedtime snacks by the staff.

Review of the facility's policy Bedtime (HS) Snacks revealed "Bedtime or HS snacks are offered to all patients. Each HS snack consists of a beverage and a snack of choice. Dietary delivers beverages and a container of snacks (i.e. vanilla wafers, graham crackers, animal crackers, etc.) to the nursing station. It is the responsibility of the nursing staff (CNAs) (Certified Nursing Assistants) to offer each patient both a beverage and a snack as a 'bedtime snack'...".

Interview on August 16, 2011, at 4:25 p.m., with CNA #5, in the hallway, confirmed bedtime snacks were not offered to all residents every night.

F 371

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

The facility must:

1. Procure food from sources approved or considered satisfactory by Federal, State or local authorities;
2. Store, prepare, distribute and serve food under sanitary conditions.

### Corrective Action:

1. The DON and ADON completed facility rounds on evening of 8/18/11 to ensure bedtime snack was offered at bedtime to all residents.
2. The DON and ADON completed random facility rounds on the evenings of 8/22/11 and 8/24/11 to ensure bedtime snacks were offered.
3. Nursing and Dietary staff was instructed by Dietary Supervisor, DON, and ADON on 8/16/11-8/25/11 regarding passing of a snack and drink to every resident before bedtime.
4. DON or designee will conduct random audits of passing and offering bedtime snacks. Activities Coordinator will also ask in monthly resident council meetings if bedtime snacks are being offered every evening. Activities director will report findings to morning meeting and results of audits to Quarterly QA Committee Meetings for six months (Oct. 20 and Jan. 19).

Completion Date: 8/31/11
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/AGENCY IDENTIFICATION NUMBER

445460

(X2) MULTIPLE CONSTRUCTION

A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED

08/17/2011

NAME OF PROVIDER OR SUPPLIER

VANCO MANOR NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

813 S DICKERSON RD
GOODLETTSVILLE, TN 37072

(X4) ID TAG SUMMARY STATEMENT OF DEFICIENCIES

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

ID TAG PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X5) COMPLETION DATE

F 371 Continued From page 16

This REQUIREMENT is not met as evidenced by:
Based on observation, review of the sanitizer test procedure, and interview, the facility failed to ensure the sanitizer solution was at the correct level, and failed to ensure expired items were not available for resident use.

The findings included:

Observation and interview, with dietary employee #1, on August 15, 2011, at 7:00 p.m., of the dietary department, revealed in the walk-in cooler, 12, 4 ounce cartons of orange juice with a expiration date of August 12, 2011. Continued observation revealed two compartment sink in use with a skillet in the quat sanitizer. Continued observation revealed dietary employee #1 tested the quat sanitizer solution obtaining a reading of 0.

Interview on August 15, 2011, at 7:15 p.m., with dietary employee #1, in the dietary department, confirmed the quat sanitizer solution was not adequate.

F 498 483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS

The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

This REQUIREMENT is not met as evidenced by:

Corrective Action:

1. On 8/15/11 the 12, 4 ounce carton of orange juice was removed from the cooler and disposed.
2. On 8/15/11 the three compartments sink was discontinued.
3. On 8/16/11 the three compartment sink chemical dispenser was serviced and repaired.
4. On 8/16/11 the Dietary Supervisor conducted a kitchen inspection to ensure compliance with food storage, preparation, and distribution.
5. On 8/26/11 the Dietary Supervisor in-serviced the dietary staff regarding proper food storage in the walk in cooler, including checking daily for the expiration date of juice & milk.
6. On 8/26/11 the Dietary Supervisor in-serviced the dietary staff on the proper use of three-compartment sink, including how to properly check the sanitizer before washing dishes.
7. The Dietary Supervisor and Regional Dietary Manager will monitor for compliance ongoing inspections of the kitchen for six months.

Completion Date: 8/26/11

F 498 483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS

Requirement:
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
**Corrective Action:**

1. CNT #4 has been in-serviced on transfer techniques by facility physical therapist and occupational therapist on corrective transfer techniques including, but not limited to, proper gait belt application and usage, proper transfer techniques with one and two persons, and proper hand placement techniques.

2. CNT #4 gave a return demonstration of all techniques and was signed off on performance checklist on 8/31/11.

3. All CNT’s on staff were in-serviced on correct transfer techniques.

4. All new hires will spend time with Physical Therapy to ensure competency in transfer techniques during orientation and it will be documented on orientation checklist. CNT’s competency will be randomly monitored by DON/ADON, and Physical Therapy to ensure compliance of skills.

5. CNT’s will be evaluated and in-serviced annually on anniversary months of hire dates. DON, ADON and/or Staffing Coordinator will monitor and check off on the anniversary date that these in-services are being completed for one year.

**Completion Date: 8/31/11**

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**Review of the personnel file for CNA #4, hired on January 25, 2001, revealed no documentation of demonstrated competency for transfer technique.**

**Interview on August 17, 2011, at 9:30 a.m., in the conference room, with the Director of Nursing, confirmed no competencies had been completed with the CNA’s related to transfer technique.**