**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER:** HUMBOLDT HEALTHCARE REHAB CENTER, INC

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 2831 AVONDALE RD P.O. BOX 446
HUMBOLDT, TN 38343

**DATE SURVEY COMPLETED:** 11/27/2012

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<table>
<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>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 282 SS=D</td>
<td>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</td>
<td>F 282</td>
<td>483.20 (k)(ii) SERVICES BY QUALIFIED PERSON PER CARE PLAN</td>
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<tr>
<td></td>
<td>The services provided or arranged by the facility must be provided by qualified persons in</td>
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<td>SS=D</td>
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<td>accordance with each resident's written plan of care.</td>
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<td>Requirement:</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
<td></td>
<td>The facility will ensure that each resident's care plan is followed by</td>
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<td>Intakes: TN0030732</td>
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<td>qualified staff within the facility.</td>
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<td>Based on medical record review, it was determined the facility failed to follow illnesses on</td>
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<td>Corrective Action:</td>
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<td></td>
<td>the care plan for behaviors for 2 of 8 (Residents #2 and 8) sampled residents.</td>
<td></td>
<td>1. On 1/28/2012 Care Plan for</td>
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<td>The findings included:</td>
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<td>Resident #2 and #8 were reviewed for accurate behavior interventions.</td>
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<td>1. Medical record review for Resident #8 documented an admission date of 6/14/11 with</td>
<td></td>
<td>2. On 11/30/2012 a Care Plan audit was conducted by Risk</td>
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<td>diagnoses of Cerebrovascular Disease, Hypertension and Diabetes Mellitus. Review of the</td>
<td></td>
<td>Management and MDS Coordinator to ensure behavior interventions were accurately</td>
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<td>care plan dated 8/12/12 documented problems and strengths of &quot;Resident has</td>
<td></td>
<td>being followed.</td>
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<td>episodes of agitation, refuses care, verbal and</td>
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<td>3. An in service was conducted on</td>
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<td>physical abusive toward staff.&quot; Review of a nurse's event note dated 8/14/12 6:30 AM</td>
<td></td>
<td>12/03/2012 by Administrator regarding following behavior</td>
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<td></td>
<td>documented, &quot;This pt [patient] was sitting in lobby</td>
<td></td>
<td>interventions on care plans.</td>
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<td>hall as 2nd [second] pt was passing by + [and] hit</td>
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<td>4. The DON, ADON and risk management will conduct routine chart audits to ensure</td>
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<td>2nd pt in the back 3 times as he passed.&quot; Review of the care plan</td>
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<td>compliance and report findings to the QA committee quarterly.</td>
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<td>updated 8/17/12 documented, &quot;aggressive behaviors hit another</td>
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<td>resident on 8/14&quot; with an intervention documented, &quot;8-17-12 keep clear of congested</td>
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<td>areas 8/14.&quot; Review of a nurse's event note dated</td>
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<td>8/26/12 at 7:05 AM documented, &quot;Staff observed this pt hit another pt on L [left] side of</td>
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**LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

Rebecca D. Brown

**TITLE**

Administrator

**DATE**

12/4/2012

*Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the institution provides sufficient protection to the patient. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days after 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.*
<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR SSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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</table>
| F 282             | Continued From page 1 [with] his fist. Pt's were immediately separated..." The nurse's event note documented the location as the lobby. The facility failed to follow the care plan intervention to, "keep clear of congested areas 8/14." 2. Medical record review for Resident #2 documented an admission date of 8/16/10 with diagnoses of Subdural Hematoma, Hypertension, Diabetes Mellitus, Schizophrenia, Parkinson's Disease, Anxiety Generalized Weakness, Mild Dementia, Excessive Libido. Review of the care plan dated 7/30/12 documented problems and strengths of "Has moods/behaviors which aren't always easily altered by staff interventions such as: hx. [history] of removing restraint and attempting to ambulate without assist; restlessness, removes clothes, socks and shoes, inattention, disorganized thinking, ans wanders in wheelchair. Dx. [diagnosis] of excessive libido, schizophrenia, depression, dementia, and anxiety." Review of a nurse's event note dated 8/14/12 at 8:30 AM documented, "CNA [Certified Nursing Assistant] reported this pt self propelling w/c [wheelchair] past another pt + pt hitting him in the back 3 times. [Name of Resident #2] was continuing on down 200 hall. 0 [no] injuries noted. Denies pain." Review of the care plan documented, "...hit on 8-14 in back x [times] 3 by another resident..." with an intervention documented, "8-14 Staff to keep pt's apart." Review of the nurse's event note dated 8/25/12 at 7:05 AM documented, "Pt was sitting in wc + propelling self in wc. This pt is confused to place + time. Pt got ^ [arrow pointing up] beside other pt + attempting to go around other pt in wc when other pt in Rm [room] hit this pt with his fist to L side of head, 0 [no] visible injury noted. This pt
<table>
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<tr>
<th>Prefix Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>Id Tag</th>
<th>Provider's Plan of Correction</th>
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<tbody>
<tr>
<td>F 282</td>
<td>Continued From page 2 redirected to other area. The facility failed to follow the care plan intervention of, 483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES</td>
<td>F 282</td>
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<td>F 319</td>
<td>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.</td>
<td>F 319</td>
<td>483.25 (f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES</td>
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<tr>
<td>SS=E</td>
<td>This REQUIREMENT is not met as evidenced by: Based on review of the facility's behavior management policy, medical record review and interview, it was determined the facility failed to ensure that residents with behaviors which might lead to conflict, such as residents with a history of aggressive behaviors and/or wandering into other resident's rooms, were assessed and had new interventions implemented after each behavioral symptom for 5 of 8 (Residents #2, 3, 4, 5, and 6) sampled residents with behavioral symptoms.</td>
<td></td>
<td>Requirements: Facility will ensure that residents with behaviors are appropriately assessed and new interventions are implemented after each behavioral symptom. Corrective Action: 1. On 11/28/2012 Resident # 2, 3, 4, 5 and 6 were assessed by MDS Coordinator for appropriate interventions reflective for current behaviors. 2. On 11/30/2012 an audit conducted by DON and MDS Coordinator to ensure that residents with behaviors had appropriate interventions reflective of current behaviors.</td>
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HUMBOLDT HEALTHCARE REHAB CENTER, INC

2031 AVONDALE RD PBOX 446
HUMBOLDT, TN 38343

[STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION]

(X1) PROVIDER/SUPPLIER/CLAUSETION NUMBER:
445454

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
11/27/2012

F 319 Continued From page 3

Sexually] 2. Verbal behavioral symptoms directed toward others [...threatening others, screaming at others,... 5. Wandering [only if the wandering places the resident at significant risk of getting to a dangerous place or encountering a dangerous situation].

INTERVENTIONS FOR BEHAVIORS 1. Non-pharmacological interventions... 2. Mental Health Services... 3. Pharmacological interventions...

2. Medical record review for Resident #2 documented an admission date of 8/16/10 with diagnoses of Subdural Hematoma, Hypertension, Diabetes Mellitus, Schizophrenia, Parkinson's Disease, Mild Dementia, Anxiety, and Excessive Libido. Review of the care plan dated 7/30/12 documented problem and strengths "Has moods/behaviors which aren't always easily altered by staff interventions such as: hx [history of removing restraints and attempting to ambulate without assist, restlessness, removes clothes, socks and shoes, inattention, disorganized thinking, and wanders in wheelchair. Dx. [diagnosis] of excessive libido, schizophrenia, depression, dementia, and anxiety."

Review of the nurse's progress notes dated 8/9/12 at 1:10 PM documented, "removed resident from rm [room] was sitting wc [wheelchair] in front of other resident. Taken to his room."

Review of the care plan update dated 8/11/12 documented problem and strength "8-11-12 Wandering into other rooms. A new intervention dated 8/11/12 documented, "8-11-12 Removed from others room + [and] redirected."

3. On 12/3/2012 in service conducted by Administrator to ensure that any behaviors exhibited have specific interventions reassessed for effectiveness.

4. The DON, ADON, Risk Management and MDS Coordinator will conduct routine chart audits and report findings to the QA Committee quarterly.

Completion Date: 12/05/2012
**F 319 Continued From page 4**

Review of the nurse’s progress notes dated 9/11/12 at 7:26 AM documented, "Patient was found in another female patient's room at about 4:00 AM, confused and lying at the foot of the female patient's bed in the nude + confused. Patient was redirected back to his room where he was dressed and put in w/c. No other adverse behaviors have been monitored."

Review of the care plan update dated 9/14/12 documented a problem/strength "wandered into another resident room + bed." The only intervention dated 9/14/12 documented, "Removed from room 9-11." Removing Resident #2 from other resident's rooms was documented as an intervention prior to this event of resident wandering into another resident's room. No new intervention was developed for this behavior.

Review of the nurse's progress notes dated 11/7/12 at 5:00 PM documented, "Pt [patient] [up] in w/c in hallway. Pt. redirected after touching a female pt. Pts separated. Will cont [continue] to monitor..."

Review of the care plan documented there was no update of the behavioral symptom of the resident touching a female resident on 11/7/12 and no new intervention was developed for the behavior.

During an interview conducted in the conference room on 10/14/12 at 12:40 PM, the Director of Nursing (DON) stated, Resident #2 touched Resident #4 in the upper leg area on 11/7/12.

3. Medical record review for Resident #3
Continued From page 5
documented an admission date of 8/3/11 with
diagnoses of Dementia, Bipolar, Anxiety, Chronic
Obstructive Pulmonary Disease, Irritable Bowel
Syndrome, Hypertension, Congestive Heart
Failure, Diabetes Mellitus, Depression and
Anxiety. Review of the care plan dated 9/10/12
documented, "Potential for mood swings due to
Manic Depression. Exhibits behaviors such as Pt
uses call light frequently, will turn light back on as
soon as staff leaves room at times, even though
staff has attended to needs; argues with
roommate, offered room change but prefers to
stay in room; makes repetitive health c/o
[complaint], easily annoyed... Behaviors not
always easily resolved by staff intervention."

Review of the nurse's progress notes dated
9/11/12 at 7:19 AM documented, "Patient was
lying in bed asking what happened + stated that
he pressed on my feet. Assessment was made
with no apparent injuries. Will cont. to monitor..."
Review of the nurse's progress notes dated
9/11/12 at 9:00 PM documented, "...Resident
states she is upset about what happened last
night. Reoriented [and] told her she will be ok.
Resident stated I am fine..." The facility was
unable to provide documentation that a new was
developed after this incident.

4. Medical record review for Resident #4
documented an admission date of 1/8/05 with
diagnoses of Arthritis, Alzheimer's Disease,
Hypertension and Dementia. Review of the care
plan dated 2/12/12 documented problem /
strengths of "Mood/behavior problems suggested
by easily annoyed. Carries a baby doll at times
and becomes upset if others touch the baby. Hx.
[history] of Repetitive statements such as '2,2,2,'
### Summary Statement of Deficiencies

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<td>F 319</td>
<td>Continued From page 6 gave it to you’. Hx of socially inappropriate behavior such as singing loudly in lobby or hallway and hx. of calling out, repetitive statements, patting/touching others; resist care at times, removes Peg [percutaneous endoscopy gastrostomy] dressing, hx of pulling braids out, and messing up hair after it is fixed; has hx of being VERBALLY and physically abusive to staff and other residents, hx of laughing loudly in public areas. Inattention, disorganized thinking, and wanders.”</td>
<td>F 319</td>
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<td>11/27/2012</td>
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Review of a nurse's event note dated 10/16/12 at 10:15 AM documented, "pt sitting in wc [wheelchair], propels self around pt [patient] is disoriented pt rolled self in wc to end of 200 Hall @ [at] window/door. Other pt was sitting in hallway @ window. This pt reached out arm toward other pt + other pt grabbed pts L [left] arm squeezing hard + digging fingers into this pts arm. Took 2 staff members to get the pt to turn loose. Pt has redness to L ^ [upper] arm + scratches x [times] 3 to L posterior arm. 0 [no] bruising noted @ this x, 0 edema noted. Moves ^ extremity s [without] diff. [difficulty] 0 s/s [signs and symptoms] pain upon movement."

Review of the care plan updated 10/19/12 documented, "Pt to pt. altercation c scratches L arm 10-16" with intervention of, "Monitor + keep pt's separated from other pt."

Review of the nurse's event note dated 10/27/12 at 8:15 AM documented, "CNA [certified nursing assistant] saw a male resident hit her in the head she immediately slapped him in face. Residents were separated."
**F 319** Continued From page 7

Review of the care plan update dated 11/3/12 documented, "Hit in head by another resident 10/27" with an intervention of, "Neuro [check mark] as ordered 10/27 pt's separated." Separating residents after an altercation was documented as an intervention prior to this resident altercation event. The facility was unable to provide documentation of a new intervention being put in place after this incident.

During an interview on 11/14/12 at 12:40 PM, the DON stated she called the nurse that had documented in Resident #2's nurse's progress notes on 11/7/17 at 4:00 PM of "Pt redirected after touching a female pt." and the nurse stated the female resident was Resident #4; she did not chart anything in Resident #4's medical record because she did not get hurt.

Review of the nurse’s progress notes, the care plan and the social service notes revealed there was no documentation of Resident #2 touching her in her upper leg area on 11/7/17. The facility was unable to provide documentation of a new intervention being put in place after this incident.

5. Medical record review for Resident #5 documented an admission date of 1/15/03 with diagnoses of Schizophrenia, Rheumatoid Arthritis, Obesity and Glaucoma. Review of the care plan dated 4/14/12 documented problems / strengths of "Has moods/behaviors as demonstrated by: disorganized thinking, easily annoyed, talks to others who are not present. hx. of verbally abusive with staff and other residents; hx. of resist care. Hx. of talking out to someone not present and waving arms in air and hitting fist against wall. Review of the nurse's progress
Continued From page 8

notes dated 8/17/12 at 8:00 PM documented, "Pt sitting @ the end of hallway in wc. Another resident came up in her wc + this pt was witnessed grabbing other pt's arms shaking resident. Resident's gotten apart + separated. Will monitor." The facility was unable to provide documentation that a new intervention was put in place after this behavior.

Review of the nurse's event note dated 10/16/12 at 10:15 AM documented, "Pt was sitting in wc @ end of 200 Hall in front of window. Other pt rolled in wc beside this pt. Other pt reached out L arm toward pt + this pt grabbed other pts arm squeezing + holding other pts L arm; digging her fingers into other pts arm. This pt becomes easily agitated + was yelling + cursing @ other pt + staff. Took 2 staff members to remove pt's hands, pts separated."

Review of the care plan updated 10/19/12 documented, "Pt to pt altercation" with a new intervention dated 10/19/12, "Pt's separated + monitored to keep apart."

Review of the nurse's event note dated 10/31/12 at 10:55 AM documented, "This pt was wheeling herself in lobby when pt from room [room number] spoke to her. Witness reports pt raised her hand to hit the other pt when other pt tried to block the hit [name of resident] then grabbed other pt's hand and was squeezing it. When she finally let go, other pt had skin tear + bruise to top of R [right] hand." The facility was unable provide documentation that a new intervention was put in place after the resident to resident altercation.

5. Medical record review for Resident #6
F 319 Continued From page 9 documented an admission date of 3/2/12 with diagnoses of Left Hip Fracture, Confusion, Urinary Tract Infection, Falls, Hypertension, Chronic Obstructive Pulmonary Disease and Osteopenia. Review of the nurse’s event note dated 10/31/12 at 10:55 AM documented, "Pt was sitting in lobby and was talking to another resident as she wheeled by this pt reached out to shake the other pt's hand when other pt grabbed this pt's hand and started squeezing it. When other pt finally let go of R [right] hand, skin tear was present + bruising was on top of R hand." The facility was unable to provide documentation that a new intervention was put in place for this resident alteration.

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<tr>
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<td>Continued From page 9 documented an admission date of 3/2/12 with diagnoses of Left Hip Fracture, Confusion, Urinary Tract Infection, Falls, Hypertension, Chronic Obstructive Pulmonary Disease and Osteopenia. Review of the nurse’s event note dated 10/31/12 at 10:55 AM documented, &quot;Pt was sitting in lobby and was talking to another resident as she wheeled by this pt reached out to shake the other pt's hand when other pt grabbed this pt's hand and started squeezing it. When other pt finally let go of R [right] hand, skin tear was present + bruising was on top of R hand.&quot; The facility was unable to provide documentation that a new intervention was put in place for this resident alteration.</td>
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