DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/Clinical IDENTIFICATION NUMBER: 445351

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
C. 11/23/2010

NAME OF PROVIDER OR SUPPLIER
SIGNATURE HEALTHCARE OF GREENEVILLE

STREET ADDRESS, CITY, STATE, ZIP CODE
106 HOLT COURT
GREENEVILLE, TN 37743

F 250 SS-D 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE

The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, review of facility policies, observation and interview, the facility failed to ensure social services was provided in a timely manner to replace dentures for one (44) of five residents reviewed.

The findings included:

Resident #4 was admitted to the facility on May 13, 2010, with diagnoses including Chronic Obstructive Pulmonary Disease, Degenerative Joint Disease, Osteoporosis, Dementia, Psychosis, Diabetes Mellitus, Depression and Failure to Thrive. Medical record review of the Minimum Data Set dated August 22, 2010, revealed the resident had short and long-term memory problems and moderately impaired decision-making skills, was totally dependent on staff for all activities of daily living and had no oral problems or weight loss.

Medical record review of a Social Worker note dated November 4, 2010, revealed the Social Worker was notified on October 26, 2010, the resident's lower dentures were missing. Review of documentation provided by the Assistant Director of Nursing revealed on October 26, 2010, the facility faxed a request to the dental service.

Signature Healthcare of Greeneville does not believe and does not admit that any deficiencies existed, either before, or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or Position and the facility reserves all rights to raise all contentions and defenses in any type of criminal Or civil claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance self critical examination Privileges which the Signature Health reserves the right to Assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its Responses, credible allegations of compliance and plan of corrections as part of its ongoing efforts to Provide quality care to our residents.

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Administrator 12/21/10
F 250 Continued from page 1 for evaluation for lower dentures for the resident.

Review of the facility's "Lost Articles" policy revealed, "Every attempt will be made to ensure that lost articles are found. All personal articles will be handled in a manner to ensure that those personal items will be returned to the appropriate resident if possible. The following procedure will outline a facility search...1. Resident/family member or staff will notify or write a notice to the Grievance Coordinator or designated department responsible for the grievance policy. 2. Using the description for the lost article, the Grievance Coordinator or designated department will search the facility and look for the missing article or articles...4. Facility will replace articles at their discretion."

Medical record review of Registered Dietician (RD) notes revealed the resident's weight in September 2010, was 96 lbs. (pounds); in October 2010, was 98.8 lbs.; and in November 2010, the weight was 90.4 lbs. Medical record review of the "Clinically Unavoidable Weight Loss/Abnormal Labs/Pressure Ulcer(s)" which had been signed by the physician and dated June 7, 2010, confirmed the resident had avoidable weight loss due to an advanced disease state of Failure to Thrive. Medical record review revealed interventions had been put in place to address potential weight loss, including multivitamins, Med Plus 2.0, regular diet with chopped meats, thin liquids, fortified foods and a sandwich snack at bedtime.

Medical record review revealed the dentist saw the resident on November 4, 2010, and made an "impression to make new lower denture."
Observation and interview on November 17, 2010, at 12:30 p.m., revealed the resident in a geri-chair in the hallway and without lower dentures in place. The resident stated, "I could eat better if I had them (lower dentures). It's hard to chew." Continued interview with the resident revealed the lower dentures had been missing "over a month."

Interview on November 18, 2010, at 8:00 a.m., with the Administrator, in the lobby, confirmed the Administrator had no knowledge of the missing dentures until October 26, 2010, when the Administrator was informed by the Social Worker.

Interview with Certified Nursing Assistant (CNA) #1 on November 19, 2010, at 9:40 a.m., in the office revealed CNA #1 had been assigned to the resident since the "first of August." Continued interview with CNA #1 revealed CNA #1 recalled cleaning the resident's upper but not the lower dentures, and CNA #1 stated, "I don't believe she ever had lower dentures."

Interview on November 18, 2010, at 9:50 a.m., in the office, with CNA #2 (who reported "taking care" of the resident since admission), confirmed the resident's lower dentures had been "missing" since August. Continued interview with CNA #2 confirmed CNA #2 had "searched everywhere" the first day the dentures were found missing and could not locate them. Continued interview with CNA #2 confirmed the family had previously inquired about the missing dentures, and CNA #2 stated, "We told the nurses."

Interview on November 18, 2010, at 11:10 a.m., with the Social Worker, in the office, confirmed the Social Worker had no knowledge of the
F 333 Continued From page 4

Review of the facility's investigation of a medication error revealed on June 21, 2010, at 7:30 a.m., Registered Nurse (RN) #1 administered the medications of resident #2 to resident #4. Continued review of the investigation revealed resident #2's medications which RN #1 administered to resident #4 included Norvasc (Hypertension) 5 mg (milligrams), Microzide (Hypertension/Edema) 25 mg, Synthroid (Thyroid replacement) 0.112 mcg (microgram), Celexa (Depression) 10 mg, Tegretol (Seizures) 100 mg, Catapres (Hypertension) 0.2 mg, Zestril (Hypertension) 20 mg and Lopressor (Hypertension) 25 mg. Continued review revealed resident #4's blood pressure after the medications were administered was 87/54.

Medical record review of the physicians' orders dated June 1-30, 2010, for resident #4 revealed none of the medications administered to resident #4 had been ordered by the physician. Medical record review of the Medication Administration Record dated June 1-30, 2010, revealed resident #4's blood pressure on June 18, 2010, (three days before the medication error) was 100/54.

Medical record review of nurses' notes dated June 21, 2010, revealed the resident's blood pressure was checked every fifteen to thirty minutes, after the medications were administered, from June 21, 2010, at 7:35 a.m., until June 21, 2010, at 2:30 p.m., and ranged from 81/54 to 110/48. Continued medical record review of nurses' notes dated June 21, 2010, revealed the IV NS was administered from 11:00 a.m., to 8:10 p.m.

Medical record review and interview on
November 17, 2010, at 11:15 a.m., in the office, with the Assistant Director of Nursing (ADON) confirmed RN #1 administered the medications listed above and ordered for resident #2, to resident #4 on June 21, 2010. Continued interview with the ADON confirmed resident #4 had no orders for blood pressure medications, and "We were concerned because (resident #4's) B/P was already a little low."

Telephone interview on November 19, 2010, at 1:15 p.m., with RN #1 confirmed RN #1 administered resident #2's medications to resident #4 on June 21, 2010. Continued interview with RN #1 confirmed the medications had been crushed and mixed with applesauce, and resident #4 had taken approximately one third of the medications before RN #1 was made aware by a Certified Nursing Assistant that the medications were being administered to the wrong resident.

F 411 ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS

1. Immediate Interventions:
   Resident #4 had dental impressions of lower dentures on 11/4/2010. Dentures are expected to be delivered by December 10, 2010.

2. Identification of the residents with potential to be affected.
   Residents who wear dentures have the potential to be affected. 100% of the residents were assessed for dentures and other appliances, and this information was placed on the residents care plan. Sixysix residents were identified as having dentures.
3. Measures to prevent reoccurrence:

In-services began on December 6, 2010, by the Director of Nursing and the Assistant Director’s of Nursing for all departments on correct procedure to report missing dentures. Absent staff will be in-serviced prior returning to work. Grievance forms are to be completed by the person taking the complaint and placed under Social Services door or given to Social Services when dentures are missing.

4. Monitoring:

Grievance forms will be reviewed with the Intra-disciplinary team consisting of Director of Nursing, Assistant Director’s of Nursing, and Social Services, daily Monday thru Friday in the clinical meeting for missing dentures. When incidents are identified, Social Services will follow up to schedule for replacement. Daily audits by the Director of Nursing will be completed Monday thru Friday times two weeks, then monthly times three to achieve compliance. Results will be reported to the performance improvement committee monthly times three to include the Medical Director, Director of Nursing, and Assistant Director’s of Nursing.
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<th>ID</th>
<th>PREPARED BY</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX TAG</th>
<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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<tbody>
<tr>
<td>F 411</td>
<td>Continued From page 8 about the missing dentures, and CNA #2 stated, &quot;We told the nurses.&quot; Interview on November 18, 2010, at 11:10 a.m., with the Social Worker, in the office, confirmed the resident had not been referred to the dental service until October 26, 2010.</td>
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