**Signature Healthcare of Greeneville**

The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiency herein.

The following plan constitutes the center's allegation of substantial compliance such that the alleged deficiencies cited have been corrected by the date(s) indicated.

**F 221:** The resident will be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

1. A quarterly physical restraint reduction assessment was completed on residents (#12, #13) on September 19, 2011
2. 100% audit was performed by DON and ADON's September 20, 2011 on residents with restraints to ensure quarterly physical restraint reduction assessments are performed.
3. The MDS Coordinators and ADON's were inserviced by DON on September 20, 2011 to ensure all

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**F 000 INITIAL COMMENTS**

An annual recertification survey and complaint investigation #28133, #28416, and #28733, were completed on September 19-21, 2011, at Signature Healthcare of Greeneville. Deficiencies were cited related to complaint investigation #28133. No deficiencies were cited related to the complaint investigation #28416 and #28733, under 42 CFR Part 483, Requirements for Long Term Care Facilities.

**F 221 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RERAINTS**

The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

This REQUIREMENT is not met as evidenced by:
- Based on medical record review, observation, and interview, the facility failed to complete quarterly physical restraint reduction assessments for two residents (#12, #13) of twenty-six residents reviewed.
- The findings included:
  - Resident #12 was admitted to the facility on August 17, 2007, with diagnoses including Dementia, Hypertension, Atrial Fibrillation, Osteoarthritis, and Osteoporosis.
  - Medical record review of the MDS (Minimum Data Set) dated August 3, 2011, revealed the resident had severe cognitive impairment, was wheelchair dependent for mobility, and required extensive

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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.
**F 221** Continued From page 1 assistance with activities of daily living.

Medical record review of a Pre-restraining Assessment dated November 22, 2010, revealed "...fall with head laceration...falls forward...leans sideways...slides down...unsteady on feet...loses balance...w/c (wheelchair) mobility...Recommendations: lap tray when up in w/c...Next Evaluation February 11, 2011..."

Medical record review of a physician's telephone order dated November 22, 2010, revealed "Place lap tray when up in W/C (wheelchair) to assist with positioning..."

Medical record review of the quarterly restraint assessments revealed no documentation of any restraint assessments completed on February 11, 2011, until April 15, 2011.

Medical record review of a Physical Restraint Elimination Assessment dated April 15, 2011, revealed a score of 30 (21-35 Good Candidate) and "...continue lap tray when up in w/c...referred to therapy for positioning...et (and) due to repeated falls..."

Medical record review of the physician's telephone order dated April 15, 2011, revealed "...lap tray to W/C when resident up in W/C due to unsafe attempts at ambulation due to dx (diagnosis) dementia..."

Medical record review of quarterly restraint assessments revealed no documentation of any quarterly restraint assessments completed in May 2011 or August 2011 until September 19, 2011.

4. The DON, Restorative Nurse, OT will review monthly x 12 months to ensure the facility is compliant with physical restraint reductions assessments and will report finding to QA team during monthly QI meetings.
Continued From page 2
Medical record review of a Physical Restraint Elimination Assessment dated September 19, 2011, revealed a score of 32 and "...continue lap tray when up in w/c..."

Observation on September 19, 2011, at 10:15 a.m., and 12:15 p.m., revealed the resident (#12) sitting in the wheelchair with a lap tray in place.

Interview with the ADON (Assistant Director of Nursing) #2 on September 20, 2011, at 1:50 p.m., confirmed the facility had not completed the resident's quarterly restraint reduction assessments in February, May, or August 2011.

Resident # 13 was admitted to the facility on August 23, 2010 with diagnoses including Dementia with Behavioral Disturbances, Hypertension, and Osteoarthritis.

Medical record review of the Minimum Data Set (MDS) dated August 9, 2011, revealed the resident had long and short term memory problems, impaired decision making, was dependent for transfers, ambulation, toileting, hygiene, and used restraints for safety.

Medical record review of the comprehensive care plan dated May 3, 2011, revealed "...resident requires physical restraint to protect (resident) from harm...geri-chair...unable to control trunk of body, leans to sides & (and) back & forward...unable to recover balance by self..."

Medical record review of a Pre-Restraining Assessment dated May 19, 2011, revealed
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<th>ID PREFIX</th>
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<tbody>
<tr>
<td>F 221</td>
<td></td>
<td>&quot;...continue use of gerichair...&quot;</td>
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<td>F 221: The facility will do a thorough investigation of injuries of unknown origin.</td>
<td>11/01/2011</td>
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<td>Medical record review revealed no documentation of a Quarterly Restraint Elimination Assessment for August 2011.</td>
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<td>Interview with Assistant Director of Nursing (ADON) #1 on Sept 20, 2011, at 8:05 a.m., at the one hundred hall nursing station confirmed the resident was placed in a gerichair on May 19, 2011, and a quarterly restraint elimination assessment was not completed until September 19, 2011, (one month past due).</td>
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<tr>
<td>F 225</td>
<td></td>
<td>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</td>
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<td>SS=D</td>
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<td>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.</td>
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<td>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.</td>
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1. A head to toe assessment was conducted by ADON on Resident # 20 September 21, 2011 to ensure no further injuries of unknown origin were noted.

2. The DON, ADON and Treatment Nurse conducted a 100% audit of residents on Sept 21-22, 2011 to
F 225 Continued From page 4
immediately to the administrator of the facility and
to other officials in accordance with State law
through established procedures (including 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
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:
Based on medical record review, review of facility
policy, and interview, the facility failed to do a
thorough investigation of two injuries of unknown
origin for one resident (#20) of twenty-six
residents reviewed.

The findings included:

Resident #20 was admitted to the facility on
August 27, 2011, with diagnoses including
Hypercalcemia (elevated calcium), Urinary Tract
Infection, and Diabetes Mellitus.

Medical record review of an Interdisciplinary
Progress Note dated January 12, 2011, at 4:40
p.m., revealed "...yellow bruising to left forehead

3. The DON in-serviced the ADON
and Restorative Nurse on September
21, 2011 and the staff on September
22-23, 2011 on identifying and
reporting injuries of unknown origin.
The staff was in-serviced by SDC,
DON, ADON on August 24-26, 2011
and again on October 4-7, 2011 on
identification and reporting abuse in
regards to injuries of unknown origin.
The DON, SDC and or Administrator
will audit incident/accident forms for
injuries of unknown origin weekly x4
weeks, bi-weekly x 4 and monthly x
12 to ensure compliance.

4. The DON will report finding to the
QA/QI team monthly x 12 months to
ensure compliance
**SIGNATURE HEALTHCARE OF GREENEVILLE**

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<td>F 225</td>
<td></td>
<td>Continued From page 5 extending down to cheek bone...&quot;</td>
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<td>Medical record review of an Interdisciplinary Progress Note dated June 13, 2011, at 6:15 a.m., revealed &quot;...discovered a bruise on resident's right posterior arm below elbow...&quot;</td>
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<td>Review of facility policy Prevention of Abuse, Neglect, and Misappropriation of Resident's Property revealed &quot;...It is the intent of this facility to thoroughly investigate...any injury of unknown origin...&quot;</td>
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<td>Interview with the Restorative Registered Nurse, in the conference room, on September 21, 2011, at 11:10 a.m., confirmed the facility could not provide documentation of thorough investigations of two injuries of unknown origin for resident #20.</td>
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<td>Interview with the Administrator and the Director of Nursing, in the Administrator's office, on September 21, 2011, at 11:45 a.m., confirmed the dates on the Witness Statements did not match the dates of injuries.</td>
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<td>F 246</td>
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<td>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</td>
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<td>SS=D</td>
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<td>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</td>
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**F 246: The facility strives to meet and will continue to provide reasonable accommodation of individual needs and preferences.**
Continued From page 6
This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, the facility failed to ensure the call light was in reach for one resident (#1) and ensure the water pitcher was in reach for one resident (#20) of twenty-six residents reviewed.

The findings included:
Resident #1 was admitted to the facility on November 1, 2010, with diagnoses including Bilateral Above Knee Amputation, Peripheral Vascular Disease, and Alzheimer’s Disease.

Observation during the initial tour on September 19, 2011, at 8:42 a.m., in the resident’s room revealed an alert resident lying on the bed with the call light not in reach of the resident.

Interview with Assistant Director of Nursing #2 (ADON), in the resident’s room, on September 19, 2011, at 8:43 a.m., confirmed the call light was not in reach for the resident and the resident occasionally used the call light to notify staff of needs.

Observation on September 19, 2011, at 12:17 p.m., in the resident’s room, revealed the resident in the wheel chair beside the bed, the call light wrapped around the side rail behind the resident and not in reach of the resident.

Interview with the Administrator, in the resident’s room, on September 19, 2011, at 12:18 p.m., confirmed the call light was wrapped around the side rail and was not in reach of the resident.

1. The ADON’s, DON, and Administrator immediately ensured the call light was in reach of resident #1 and the water pitcher was in reach of resident #20 and then conducted a 100% Audit of call lights on September 19, 2011 and water pitchers on September 20, 2011 to ensure they are in reach of residents.

2. The ADON’s and charge nurses audited 100% of residents rooms to ensure water pitchers and call lights are within reach of residents.

3. The ADON’s and charge nurse will monitor all facility resident rooms daily x 14 days then monthly x 3 months to ensure water pitchers and call lights are within reach of residents. On September 20, 2011 the nursing staff was in-serviced by DON, ADON, SDC on ensuring call lights and water pitchers are in reach of residents. Further on October 4-7, 2011 all staff was in-serviced by SDC and DON regarding reasonable
F 246 Continued From page 7

Resident #20 was admitted to the facility on August 27, 2011, with diagnoses including Urinary Tract Infection, Diabetes Mellitus and Hypercalcemia (elevated calcium).

Observation on September 20, 2011, at 4:30 p.m., in the resident's room, revealed the resident sitting in the wheel chair, the water pitcher on the bedside table not in the resident's reach, and the resident asking for a drink of water.

Interview with the Restorative Registered Nurse, in the resident's room, on September 20, 2011, at 4:37 p.m., confirmed the resident was able to pick up the water pitcher without assistance and drink for several minutes, however, the water pitcher was not in the resident's reach.

F 274 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE

A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

This REQUIREMENT is not met as evidenced

accommodations of resident needs and preferences.

4. The QA Team will monitor for proper placement of call lights and water pitchers during daily rounds and report findings to Administrator and DON. The Administrator or DON will report findings to monthly QA/QI meeting.

F 274: The facility strives to complete a comprehensive assessment of all residents within 14 days after a significant change has been noted.

1. The MDS immediately completed a significant change MDS for resident#24.

2. The MDS audited 100% of hospice residents on September 21, 2011 to
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<tr>
<td>F 274</td>
<td>Continued From page 8 by: Based on medical record review and interview the facility failed to conduct a full assessment of one resident (#24) following a significant change of twenty-six residents reviewed. The findings included: Resident #24 was admitted to the facility on February 1, 2003, with diagnoses including Dementia and Chronic Obstructive Pulmonary Disease. Medical record review revealed the resident became a Hospice resident on June 28, 2011, following a marked decline, precipitating repeated hospitalizations from February 2011 through May 2011. Medical record review of the Minimum Data Sets (MDS) revealed the last full MDS was completed with the Care Area Assessment on March 14, 2011. Interview with the MDS Coordinator, in the conference room on September 20, 2011, at 12:00 p.m., confirmed the facility had failed to complete a full MDS Significant Change with the accompanying Care Area Assessment in June 2011, when the resident's health had declined and Hospice care began for the resident.</td>
<td>F 274</td>
<td>ensure the MDS significant change had been completed. 3. The MDS coordinators were serviced by DON on September 21, 2011 to ensure completion of significant changes on all residents with hospice care. 4. The DON will monitor all hospice patients monthly x 12 to ensure significant change MDS’s are completed. The DON will report findings to monthly QA/QI meeting to ensure compliance.</td>
<td>11/01/2011</td>
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<td>F 279 SS=E</td>
<td>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</td>
<td>F 279</td>
<td>F 279: The facility will continue to use the results of the assessments to review and revise residents comprehensive care plans.</td>
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The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview the facility failed to develop a comprehensive care plan to address bilateral amputations for one resident (#4), failed to update a care plan for one resident (#11), failed to develop a care plan after readmission for one resident (#20), and failed to address falls risk for one resident (#25) of twenty-six residents reviewed.

The findings included:

Resident #4 was readmitted to the facility on June 11, 2011, with diagnoses including Diabetes, Traumatic Amputation, Neurogenic Bladder, and Bipolar Disorder.

Medical record review of the MDS (Minimum Data Set) dated June 18, 2011, revealed the resident
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<td>F 279</td>
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<td>Continued From page 10 was 15 out of 15 for the BIMS (brief interview for mental status) and required extensive assistance for bathing and hygiene.</td>
<td>F 279</td>
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<td>3. The ADON’s/Supervisor will audit new admits/readmits charts for completion of interim care plans within 24 hours to ensure care plan is reflective of residents condition. The DON will audit comprehensive care plans weekly x 4 weeks, monthly x 3 months then quarterly x 2 quarters to ensure comprehensive care plans are reflective of resident care.</td>
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<td>Medical record review of the care plan dated June 15, 2011, revealed the care plan did not include interventions for the bilateral amputations.</td>
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<td>4. The Administrator and DON will present audits to QA/QI team monthly x 6 months to ensure compliance.</td>
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<td>Interview with MDS Coordinator #1 on September 20, 2011, at 4:15 p.m., in the MDS office, confirmed the care plan did not include interventions for the bilateral amputations.</td>
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<td>Resident #11 was readmitted to the facility on April 27, 2011, with diagnoses including After care of a Fracture of the Hip, Senile Dementia, Hypertension, and Hypothyroidism.</td>
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<td>Medical record review of a Fall/Change in Function Status form dated April 21, 2011, revealed the resident had a fall and sustained a fracture of the right hip.</td>
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<td>Medical record review of the care plan updated on July 18, 2011, revealed the care plan did not address the fall on April 21, 2011, or the resident having a fracture of the right hip.</td>
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<td>Interview with the MDS Coordinator on September 20, 2011, at 4:20 p.m., in the MDS office, confirmed the care plan did not address the fall or hip fracture.</td>
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<td>Resident #20 was admitted to the facility on August 20, 2011, with diagnoses including Urinary Tract Infection, Diabetes Mellitus and Hypercalcemia (elevated calcium).</td>
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F 279: Continued From page 11

Interview with Registered Nurse Care Plan Coordinator, in the care plan office on September 21, 2011, at 9:30 a.m., confirmed a Comprehensive Care Plan had not been developed for resident #20.

Resident #25 was admitted to the facility on April 27, 2011, with diagnoses including both recent and remote Myocardial Infarctions, Congestive Heart Failure, Urinary Tract Infection, and recent history of Falls.

Medical record review of the April 27, 2011, Admission Nursing Assessment (including a Falls Assessment) revealed the resident was at risk for falls.

Medical record review of the initial care plan dated April 27, 2011, revealed the plan of care did not address the resident being at risk for falls.

Interview with the administrator, in the administrator's office at 11:55 a.m., on September 21, 2011, verified the resident's initial plan of care did not address the resident being at risk for falls.

F 309: The facility will continue to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being.

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.
F 309  Continued From page 12

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, the facility failed to have communication to ensure coordination of care with the Hospice provider for two residents (#15 & #1) of twenty-six residents reviewed.

The findings included:

Resident #15 was admitted to the facility on June 30, 2003, with diagnoses including Congestive Heart Failure, Diabetes, Dysphasia, and Hypertension.

Medical record review of the MDS (Minimum Data Set) dated May 20, 2011, revealed the resident was unable to complete the BIMS (brief interview for mental status).

Medical record review of the Hospice record (separate medical record) revealed Hospice had a Hospice care plan/check list worksheets (daily) for visits for care provided. The care plan/worksheet list included showers, vital signs, shampoo and groom hair, and etc. that was to be performed on the day of the hospice visit.

Continued review revealed the check list had a code system for Hospice services to document the services provided (#, 37) on each visit.

Interview with the ADON #2 (Assistant Director of Nursing) on September 20, 2011, at 4:00 p.m., at the central nurses’ station, confirmed the staff had no knowledge of the code system for the Hospice services being provided, and had no

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<td>F 309</td>
<td>Continued From page 12</td>
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<td>1. The facility immediately called the hospice provider for a key to codes of care for residents #15 and #1. These codes were placed in residents 15 and 1 chart. The ADON's in-serviced the nursing staff on codes on September 20, 2011.</td>
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<td>2. 100% audit of hospice residents charts was conducted by ADON's on September 20, 2011 for placement of key codes of services provided.</td>
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<td>3. The nursing staff was in-serviced by ADON's on September 21, 2011 and again on October 4-7, 2011 regarding the key code system for residents on hospice. The ADDON's will audit hospice charts monthly x 12 to ensure key code is in residents chart. Licensed nurses will be randomly interviewed weekly x 4 weeks, then monthly x 3 months, and then quarterly x 2 quarters to ensure proper understanding of hospice key code system. The DON will review weekly starting 10/4/2011 a schedule of hospice dates of services with a</td>
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F 309 Continued From page 13
knowledge of when or what days the Hospice staff visited.

Resident #1 was admitted to the facility on November 1, 2010, with diagnoses including Bilateral Above Knee Amputation, Peripheral Vascular Disease, and Alzheimer's Disease.

Medical record review of the MDS dated June 15, 2011, revealed the resident had short and long term memory problems, severely impaired decision making, and required total dependence for all (ADL) activities of daily living.

Medical record review revealed Hospice had a separate binder at the nurse's station from the resident's facility chart which included a Hospice Care Plan for the nurses and hospice visit documentation. Further medical record review of the Hospice documents revealed no documentation of scheduled visits or care to be provided by the Hospice staff. Further medical record review of the Hospice documentation revealed the Hospice staff utilized a number and symbol code system to indicate care provided on visits and no documentation was provided to the facility to explain the code system utilized.

Interview with (LPN) Licensed Practical Nurse #2 on September 19, 2011, at 3:36 p.m., in the resident's room, confirmed the staff had no knowledge of days the Hospice staff visited or how Hospice staff documented care provided.

Interview with the ADON #2 on September 19, 2011, at 3:45 p.m., at the Skilled Hall Nurses hospice representative and will post at nurses station for licensed nursing staff to ensure communication of service dates to staff.

4. The Director of Social Services or assistant will meet weekly with DON to ensure hospice date of service has been posted at nurses station and the SW will audit all hospice charts monthly to ensure key codes are present. The SW will report findings to QA/QI team to ensure compliance.
Continued From page 14
Station, confirmed the staff had no knowledge of the code system for the Hospice care being delivered.

F 312: Our residents will continue to receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

1. Resident #4 was immediately given a shower on September 21, 2011

2. All Residents were interviewed by ADON’s on September 21, 2011 regarding availability and access of showers. No resident voiced a need for a shower at that time. Residents are provided showers Monday, Tuesday, Thursday, and Friday.

3. The CNA’s and licensed nursing staff were in-serviced by DON on September 21, 2011 and again on October 4-7, 2011 regarding availability and access of showers. The ADON and charge nurses will
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<tr>
<td>F 312</td>
<td>Continued From page 15 revealed the resident had been asking for a shower for over a week and was told by staff, &quot;don't have time.&quot; Continued interview revealed the resident stated &quot;...sometimes it's weeks before able to get a shower, would love to have one.&quot; Interview with the Staff Development Coordinator, on September 21, 2011, at 9:35 a.m., at the central nurses' station, confirmed the resident had not been showered from August 4-25, 2011, (a total of 22 days).</td>
<td>interview residents at various times, 2x a week for 4 weeks and then weekly x 4 weeks to ensure compliance with showers. 4. The DON will audit ADL tracking forms daily x 14 then weekly x 4 weeks to ensure availability/access to showers by residents. The DON will report her findings to QI/QA.</td>
<td>11/01/2011</td>
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<td>F 314</td>
<td>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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: Based on medical record review and interview the facility failed to conduct complete assessments and properly track two residents' (#1, &amp; #24) pressure ulcers out of five residents reviewed for pressure ulcers.</td>
<td>F 314: The facility will continue to ensure that a resident who enter the facility without pressure sores does not develop them unless their clinical condition demonstrates that they were unavoidable. 1. The treatment nurse immediately assessed resident #1 pressure ulcers and documented their condition on tracking form and skin assessment sheet to include onset date and location of tunneling. The pressure mattress for resident #1 was adjusted to meet the resident's current weight of 72 pounds. Resident # 24 expired</td>
<td>11/01/2011</td>
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Resident #1 was admitted to the facility on November 1, 2010, with diagnoses including Bilateral Above Knee Amputation, Peripheral Vascular Disease, and Alzheimer's Disease.

Medical record review of the (MDS) Minimum Data Set dated June 15, 2011, revealed the resident had short and long term memory problems, severely impaired decision making, required total dependence for all (ADL) activities of daily living, four stage two pressure ulcers, one stage four pressure ulcer, and the date of the oldest stage two pressure ulcer as "...12-22-2010..."

Medical record review of the Weekly Pressure/Ulcer Tracking dated December 9, 2010, revealed the resident had "...stage one decub (decubitus) on coccyx...1.5 cm (centimeters) x 2 cm...no depth...date of occurrence 11/11/10 in house..." Further medical record review of the Weekly Pressure/Ulcer Tracking dated December 31, 2010, revealed the resident had "...rt (right) lower butt (buttocks)...3.75 cm x 3.5 cm x <.25 cm date of occurrence 12/22/2010 in house...stage two decub...7.5 cm x 1.5 cm x <.25 cm..." Further medical record review of the Weekly Pressure/Ulcer Tracking dated January 7, 2011, revealed, "...rt butt stage two...3.75 cm x 3.5 cm x .25 cm..." with no documentation of a pressure ulcer on coccyx.

Medical record review of the Individual Skin Report dated June 14, 20, and 27, 2011, revealed tunneling at "...1 o'clock..." Further medical...
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
SIGNATURE HEALTHCARE OF GREENEVILLE

<table>
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<tr>
<th>ID</th>
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<tr>
<td>F314</td>
<td>Continued From page 17 record review of the Individual Skin Report dated July 7, August 23 and 30, 2011, revealed tunneling at &quot;...11 o'clock...&quot; Observation of a dressing change on September 19, 2011, at 1:20 p.m., with LPN #2, revealed the following measurements: right buttocks pressure ulcer measuring 6 cm x 2.5 cm x 1 cm with 1.7 cm tunneling at 6 o'clock and 1.5 cm tunneling at 1 o'clock. Interview with LPN #2 on September 20, 2011, at 4:00 p.m., in the conference room, verified the Weekly Pressure/Ulcer Tracking forms and the Individual Skin Reports had inconsistencies of onset date, location of tunneling, and assessments. Interview confirmed the pressure ulcers had not been accurately assessed. Observation on September 19, 2011, at 8:43 a.m., in initial tour in the resident #1's room, revealed a pressure relieving mattress with a setting of &quot;...140 lbs (pounds)...&quot;, Interview with (LPN) Licensed Practical Nurse #1 on September 19, 2011, at 3:36 p.m., in the resident's room, verified the pressure mattress with a setting of 140 lbs and confirmed there was no documentation or staff knowledge of the correct settings. Interview with LPN #3 on September 20, 2011, at 10:35 a.m., in the resident's room, revealed the resident weighed seventy two pounds and the mattress setting was presently at 70 lbs. Interview confirmed the resident's mattress had to be set according to resident's weight in order to be pressure reducing.</td>
<td>F314</td>
<td>2011 with treatment nurse to ensure proper assessment, treatment and documentation of pressure ulcers. The DON and ADON's will review pressure ulcer tracking forms and skin assessments weekly x 4 weeks, then monthly x 3 months, then quarterly x 2 quarters and report findings to at risk committee. September 20, 2011 a representative of pressure mattress company came to facility and in-serviced the direct care staff on proper settings of pressure mattress. 4. The QA/QI team will review pressure ulcer reports monthly to ensure compliance.</td>
<td>09/21/2011</td>
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Resident #24 was admitted to the facility on February 1, 2003, with diagnoses including Dementia and Chronic Obstructive Pulmonary Disease. Medical record review revealed the resident was admitted to the hospital February 19, 2011, with Aspiration Pneumonia following an increase in Dysphagia related to progressive Severe Dementia.

Medical record review of the nursing notes from February through June 2011, revealed the resident was receiving a continuous tube feeding from February 2, 2011, was not able to eat due to Dysphagia, and was totally dependent for all activities of daily living.

Medical record review revealed the resident was readmitted to the hospital on May 6, 2011, and returned May 12, 2011, with four pressure ulcers of the buttocks and coccyx in close proximity.

Medical record review of the Weekly Skin Rounds revealed an open area of the left buttock was identified on April 1, 2011. Review of the Weekly Skin Rounds documented, "no open areas" on April 8 & 11, 2011. Review of the Weekly Skin Rounds documented on April 15, 2011, revealed "L (left) buttock open x 3...R (right) with open area." Review of the Weekly Skin Rounds documented on April 22, 2011, Red L buttock and R buttock open area." Medical record review revealed a Weekly Pressure Ulcer Tracking Assessment was not initiated until May 28, 2011.

Medical record review of the April and May physician's orders revealed the pressure ulcer...
### F 314
Continued from page 19

Treatment was to apply a protective barrier from April 1, 2011, until May 20, 2011, when a debriding agent was ordered for the pressure ulcer. Record review revealed a physician's order for antifungal cream to back and buttocks on May 25, 2011, and for an indwelling urinary catheter on May 27, 2011.

Medical record review revealed the Nurse Practitioner documented "Wound Rounds" on May 13, 2011, "...small open areas Medial aspect - total 3 areas...At risk for worsening secondary to immobility and stooling..." Medical record review revealed the Nurse Practitioner documented on May 27, 2011, "...worsening fungal rash and decub wound larger in circumference and open in the center..."

Medical record review of the Weekly Pressure Ulcer Tracking Assessments revealed there were only two weeks, the week of May 28, and the week of June 4, 2011, when the weekly assessment of the pressure ulcer and tracking for the effectiveness of the treatment ordered was completed.

Medical record review revealed the Nurse Practitioner documented on June 8, 2011, "...wounds look better..."

Medical record review revealed the resident became a Hospice resident on June 28, 2011, following a marked decline related to Severe Dementia, Dysphagia, repeated Upper Respiratory and Urinary Tract Infections requiring numerous antibiotics. Medical record review revealed Chronic Diarrhea developed related to the repeated use of antibiotics.
F 314 Continued From page 20

Interview with the administrator, in the administrator's office at 8:55 a.m., on September 21, 2011, verified the wound care nurse is responsible to track all pressure ulcers weekly, including the exact site, the stage, width/length, odor or drainage, the appearance of the wound bed, the appearance of the tissue surrounding the pressure ulcer, the treatment and the progress of the ulcer. Interview confirmed the resident's pressure ulcer had deteriorated from May 13 to May 28 when it was not being tracked weekly. Interview verified the Nurse Practitioner had participated in addressing the resident's wounds from May 13-June 8, 2011, but this did not replace the weekly assessment nursing was responsible to perform. Interview verified the resident's deteriorating health contributed to the pressure ulcer development and non-healing. Interview confirmed the week of May 28, and the week of June 4, 2011, were the only two Weekly Pressure Ulcer Tracking assessments done by the wound care nurse.

C/O #28133
483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

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

This REQUIREMENT is not met as evidenced

F 323: The facility will continue to ensure that the resident environment remains as free of accident hazards as is possible.

1. Resident #11 safety devices were checked by licensed nurse and central supply stakeholder on September 20, 2011 to ensure proper
**F 323** Continued From page 21

by:

Based on medical record review, review of facility investigation, observation, and interview, the facility failed to ensure safety devices used to alert staff of unassisted transfers were working to prevent falls resulting in a fracture of the hip (Harm) for one resident (#11) of twenty-six residents reviewed.

The findings included:

Resident #11 was admitted to the facility on August 11, 2009, and readmitted on April 27, 2011, with diagnoses including After care of a Fracture of the Hip, Senile Dementia, Hypertension, History of Falls, and Hypothyroidism.

Medical record review of the Minimum Data Set (MDS) dated April 21, 2011, revealed the resident scored 4 out of 15 on the BIMS (Brief Interview for Mental Status), (0-7 is severe cognitive impaired), was one person assist for transfers, and walk in room.

Medical record review of a Fall Risk Evaluation dated April 21, 2011, revealed a score of 16 (total score of 10 or higher is at risk).

Medical record review of the Nurse's Notes dated August 29, 2010 thru November 11, 2010, revealed the resident had experienced several falls from the bed with no injuries. Medical record review of the care plan dated November 12, 2010, revealed the resident sustain a fall from the wheelchair with no injury and a chair alarm was placed on November 14, 2011, to alert staff of any unassisted transfers.

functioning. The MDS coordinator reviewed resident #11 care plan on September 20, 2011 to ensure all falls and interventions were care planned.

2. 100% audit of safety devices were assessed by central supply stakeholder on September 21, 2011 to ensure proper functioning. MDS began auditing on September 21, 2011 all residents care plans for falls and interventions.

3. The activity staff was in-serviced, as well as, all staff regarding safety devices on use and purpose on September 21, 2011 and again on October 4-7, 2011 by DON and SDC. The nursing staff was in-serviced on September 21, 2011 and again on October 4-7, 2011 on resident safety and transfers during toileting. Central supply stakeholder has placed a book in central supply office on September 21, 2011 listing safety devices and a schedule for checking for proper functioning. The licensed nurse will check patient safety.
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| F 323     |     | Continued From page 22

Medical record review of a Fall/Change in Functional Status, dated April 21, 2011, revealed "...res (resident) attempted to toilet self per report from staff...res observed lying on r (right) side on floor in bathroom on main hallway...shoes on...brief & pants wet, pants pulled down to directly below brief...chair alarm in place and on but not sounding...res states...was standing in front of mirror when...lost...balance falling to R (right) landing on R hip and R arm..." Review of the facility's investigation dated April 21, 2011, revealed staff member in activities reported turning alarm off.

Medical record review of a nurse's note dated April 21, 2011, at 5:00 p.m., revealed "...Transferred to EMS (emergency medical services) stretcher..."

Medical record review of a nurse's note dated April 21, 2011, at 7:45 p.m. revealed "...Received call from (named) hospital ER (emergency room)...res. (resident) admitted to hospital with R femoral neck fx (fracture)...Surgery scheduled for sometime tomorrow..."

Medical record review of the hospital x-ray report dated April 21, 2011, revealed "...Displaced, angulated right femoral neck fracture..."

Medical record review the resident was in the hospital from April 21 thru April 27, 2011, and was readmitted to the facility.

Observation on September 20, 2011, at 8:00 a.m., revealed the resident was sitting in a wheelchair in the hallway with chair alarm on and devices (alarms) q shift to ensure proper functioning. The Restorative nurse will monitor safety device books every two week x 4 weeks and then monthly x 12 months.

4. The Restorative nurse will provide safety device book to QA/QI team monthly to ensure compliance.
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| F 323 | Continued From page 23
| | working. Observation on September 20, 2011, at 1:00 p.m., revealed the resident lying in bed with bed alarm in place.
| | Medical record review of the care plan undate on July 18, 2011, revealed the care plan did not address the fall or no intervention put in place.
| | Interview with the MDS (Minimum Data Set) Coordinator on September 20, 2011, at 4:20 p.m., in the MDS office, confirmed the facility failed to develop any new interventions on the care plan to prevent any further unassisted transfers or falls.
| | Interview with ADON #1 (Assistant Director of Nursing) and the Restorative Nurse on September 20, 2011, at 11:45 a.m., in the restorative office, confirmed the chair alarm was not turned on at the time to alert staff of unassisted transfers resulting in a fall and fracture of the right hip (Harm).
| F 441 | The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.
| SS=D | (a) Infection Control Program
| | The facility must establish an Infection Control Program under which it -
| | (1) Investigates, controls, and prevents infections in the facility;
| | (2) Decides what procedures, such as isolation, should be applied to an individual resident; and
| | (3) Maintains a record of incidents and corrective
| F 441 | F 441: The facility will continue to maintain an infection control program designed to provide a safe, sanitary, and comfortable environment.
| | 1. The treatment nurse washed her hands, the med cart was immediately wiped with a disinfectant and the wound cleanser bottle was disregarded and replaced with a new one. Resident #1 was assessed on

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If continuation sheet Page 24 of 33
Continued From page 24 actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, review of facility policy and interview the facility failed to perform proper hand hygiene for one resident (#1) of twenty-five residents reviewed.

The findings included:
Resident #1 was admitted to the facility on November 1, 2010, with diagnoses including Bilateral Above Knee Amputation, Peripheral Vascular Disease, and Alzheimers Disease.

Observation of the dressing change on September 21, 2001 by Nurse Practitioner for signs or symptoms of infection. There was none. The ice scoop and cooler was removed from floor and disinfected. The CNA washed her hands.

2. All residents with pressure ulcers were assessed on Sept 21, 2011 by DON, Nurse Practitioner and charge nurses for sign and symptoms of infection. There were none present. All ice coolers and scoops were removed from floor and disinfected on Sept 21, 2011 by dietary staff.

3. The DON in-serviced the treatment nurse regarding proper hand washing techniques on September 20, 2011. The CNA's were in-serviced on September 21, 2011 and again on Oct 4-7, 2011 on infection control regarding ice pass. The Nurse Practitioner and or DON will observe the treatment nurse for proper hand washing, dressing changes techniques, and sanitary use of supplies daily for 7 days then...
F 441 Continued From page 25

September 19, 2011, at 1:20 p.m., in the resident's room, with Licensed Practical Nurse (LPN) #2, revealed LPN #2 opened the dressing supplies on top of the treatment cart, opened the dirty trash can lid on the side of the treatment cart, placed the trash in the container, closed the lid, and without washing the hands opened another clean package on the treatment cart, opened the dirty trash can lid on the side of the treatment cart, placed the trash in the container, and closed the lid. Continued observation revealed without washing the hands LPN #2 picked up the clean supplies, entered the resident's room, placed the supplies on the overbed table, donned gloves, and removed the old dressing. Continued observation revealed after washing the hands and changing gloves LPN #2 used a spray bottle of wound cleanser with gloved hands to cleanse the wound touching the resident's bed covers with the spray bottle. Continued observation revealed after completing the dressing change, LPN #2 exited the resident's room, cleaned only the trigger of the bottle of wound cleanser (not portion of bottle touching resident covers) with an alcohol pad, and placed the dirty wound cleanser bottle back into the treatment cart for continued use with other residents.

Review of facility policy, Non-Sterile Dressing Change, revealed "...Discard all used supplies in trash bag..."

Review of facility policy, Hand Washing, revealed "...hand washing will be performed...after contact with surfaces which are contaminated..."

Interview with LPN #2 on September 19, 2011, at weekly x 4 weeks and then quarterly to ensure proper infection control procedure are adhered too. The SDC and/or ADON will monitor ice pass on each hall on each shift 3 x week for 2 weeks then weekly for 4 weeks then monthly x 12.

4. The Nurse Practitioner, DON, and or SDC will report findings to QA/QI Team monthly to ensure compliance.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

445351

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
09/21/2011

NAME OF PROVIDER OR SUPPLIER

SIGNATURE HEALTHCARE OF GREENEVILLE

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

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

F 441 Continued From page 26
1:50 p.m., in the hallway outside the resident's room, confirmed the contaminated lid was opened, on two separate occasions, with the cleaned hands, and LPN #2 failed to wash the hands after touching the dirty lid. Continued interview with LPN #2 confirmed the wound cleanser bottle was contaminated during the dressing change with the use of dirty gloves and was not completely cleaned before being placed back in the treatment cart for use on other residents.

Observation on September 21, 2011, at 9:18 a.m., on Skilled One Hall, revealed the following:
(CNA) Certified Nurse Technician #2 filling the residents water pitchers with ice, placing the ice scoop in the pitchers already used by the resident's, without cleaning the scoop in between the residents, and not washing the hands between residents.

Interview with CNA #2 on September 21, 2011, at 9:20 a.m., on the Skilled One Hall, confirmed the ice scoop was contaminated when placed in the used resident's water pitchers, the ice scoop had not been cleaned between the water pitchers, and the CNA had not washed the hands in between the residents.

Observation on September 21, 2011, at 9:35 a.m., on the Skilled One Hall, with ADON #2 (Assistant Director of Nursing), revealed CNA #2 continuing to pass ice with gloves on, entered the resident's rooms, not changing the gloves, and not washing the hands between the residents.

Interview on September 21, 2011, at 9:35 a.m.,
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER:** Signature Healthcare of Greeneville

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
106 Holt Court
Greeneville, TN 37743

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<td>F 441</td>
<td>Continued From page 27 on the Skilled One Hall, with ADON #2, confirmed CNA #2 had passed ice to the residents in multiple rooms, with the gloved hands, had not washed the hands or changed the gloves between the residents, and had not followed proper infection control practices.</td>
<td>F 441</td>
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<td>11/01/2011</td>
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<tr>
<td>F 514</td>
<td>483.75(1)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</td>
<td>F 514</td>
<td>Continued From page 27 on the Skilled One Hall, with ADON #2, confirmed CNA #2 had passed ice to the residents in multiple rooms, with the gloved hands, had not washed the hands or changed the gloves between the residents, and had not followed proper infection control practices.</td>
<td>11/01/2011</td>
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<tr>
<td>SS=D</td>
<td>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to document ADL care (Activity of Daily Living) for four residents (#3, #6, #16 and #20) and failed to document Skilled Nursing Services for one resident (#25) twenty-six residents reviewed. The findings included: Resident #3 was readmitted to the facility on March 18, 2011, with diagnoses including CVA (Cerebral Vascular Accident) and Persistent</td>
<td></td>
<td>1. September 21, 2011 the ADON's reviewed current ADL flow sheets for residents #3, #6, #16, #20 for documentation of showers/complete bath. All documentation was accurate and complete for showers and baths. Resident #25 had no current documentation related to skilled services because resident #25 had expired on August 16, 2011. 2. 100% audit of ADL sheets were completed by ADON's on September 21-23 for documentation of showers and complete baths. 100% audit of skilled charts was performed on September 21, 2011 by ADON's for</td>
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Vegetative State.

Medical record review of the MDS (Minimum Data Set) for resident #3, dated June 8, 2011 revealed the resident was completely dependent on staff for all ADLs.

Medical record review of the CNA (Certified Nursing Assistant) - ADL (Activities of Daily Living) Tracking Form for the month of July 2011, revealed documentation that resident #3 had only one shower or complete bath for three of the four weeks in July.

Resident #6 was admitted to the facility on July 9, 2010, with diagnoses including Pneumonia, CVA with Organic Brain Damage, and Persistent Vegetative State.

Medical record review of the MDS for resident #6, dated June 30, 2011, revealed the resident was completely dependent on staff for all ADLs.

Medical record review of the CNA-ADL Tracking Form for the month of August 2011 revealed no documented shower or complete bath for the dates of August 10 through August 22, 2011 (12 days). Continued medical record review of the CNA-ADL Tracking Form for July 2011, revealed no documented shower or complete bath for July 20th through July 31, 2011 (11 days).

Interview with CNA #1 and RN #1 on September 20, 2011, at 1:10 p.m., at the 1 South nurse’s station confirmed the medical records did not contain documentation of showers or complete baths that had been given for residents #3 and #6.

daily presentation of skilled documentation.

3. On September 21, 2001 and again on October 4-7, 2011 the DON in-serviced the cna’s on proper and complete documentation of residents ADL’s on ADL tracking forms. The licensed nurses were in-serviced on September 21, 2001 and again on October 4-7, 2011 on appropriate daily documentation of skilled services. The ADON’s will audit ADL sheets daily x 14 days, then weekly x 4 weeks then quarterly x 2 quarters to ensure showers/complete baths are documented. ADON’s will audit all skilled residents’ charts for daily skilled documentation everyday x 14 days, weekly x 4 weeks, then monthly x 3 months, then quarterly x 2 quarters.
Further interview on September 21, 2011, at 10:00 a.m., in the central hall dining room, with CNA #5 who regularly cares for the residents (#3, #6) and provides the resident’s ADL care revealed CNA #5 stated "...I am sure that they were bathed at least every other day..." CNA #5 confirmed the medical record did not accurately reflect the ADL care provided for residents #3 and #6.

Medical record review and interview on September 21, 2011 at 10:40 a.m., in the main conference room, with the Director of Nursing (DON) and Administrator, confirmed baths and/or showers were provided but the medical record was not complete and did not reflect the ADL care provided for residents #3 and #6.

Resident #16 was admitted to the facility on December 3, 2010, with diagnoses of Hypertension, Depression, and Late Effects of Bilateral Lower Extremity Fractures.

Medical record review of the Minimum Data Set (MDS) dated August 9, 2011, revealed the resident had problems with short and long term memory, impaired decision making, was dependent for transfers, and required extensive assistance with personal hygiene, bathing and continence.

Medical record review of facility documentation labeled Skin Care Assessment Sheet and CNA (Certified Nursing Assistant) ADL (Activity of daily living) Tracking Forms dated 7/11 (July, 2011) revealed on week of July 13, 2011, the resident missed one shower. Further review of the CNA
F 514 Continued From page 30
ADL Tracking Sheet dated 8/11 (August, 2011) revealed week of August 14, 2011, the resident missed two showers.

Interview on September 21, 2011, at 10:15 a.m., in the two hundred hall nursing station, with CNA #4, revealed personal care was documented on Skin Care Assessment Sheets, were not part of the medical record, and were turned in to the treatment nurse at the time the care was provided. Further interview revealed the care was to be documented in the medical record on the CNA/ADL tracking form later in the shift. Further interview confirmed residents were provided with baths and showers as scheduled, but the CNA's documented the care on three different tracking forms and the medical record was not complete to reflect care provided.

Medical record review and interview on September 21, 2011 at 10:40 a.m. in the main conference room with Director of Nursing (DON) and Administrator confirmed baths and showers were provided as scheduled but the medical record was not complete and did not reflect the care provided.

Resident # 20 was admitted to the facility on August 27, 2011, with diagnoses including Urinary Tract Infection, Diabetes Mellitus and Hypercalcemia (elevated calcium).

Medical record review of the CNA-ADL Tracking Form for the month of July 2011, revealed no documentation of a shower or complete bath for July 1 through 7, and one shower documented for July 15 through 21 for resident #20. Further
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<td>review of the CNA-ADL Tracking Form for August 2011, the resident had one shower for two of the four weeks in August, and not two showers or baths as scheduled.</td>
<td>Review of medical records and interview on September 21, 2011 at 10:40 a.m., in the main conference room with the Director of Nursing (DON) and the Administrator confirmed baths and showers were provided as scheduled but the medical record was not complete and did not reflect the care provided.</td>
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<tr>
<td>Interview on September 21, 2011 at 10:28 a.m. in the two hundred hall nursing station with Assistant Director of Nursing one (ADON #1) confirmed the facility tracks personal care provided to residents on two different forms and are not part of the medical record.</td>
<td>Resident #25 was admitted to the facility on April 27, 2011, with diagnoses including both recent and remote Myocardial Infarctions, Congestive Heart Failure, Urinary Tract Infection, and recent history of Falls.</td>
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<td>Medical record review of the resident's complete closed record from April 27, 2011, until the resident expired at the facility on August 16, 2011, revealed the resident was a skilled nursing resident throughout the stay.</td>
<td>Medical record review of the Interdisciplinary Progress Notes (ID Notes) revealed the nursing staff documented the daily skilled nursing care and concerns within the ID Notes. Record review revealed the nursing staff failed to document</td>
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F 514 Continued From page 32
skilled care on the following days: May 6, 7, 8, 11, 12, 13, 14, 21, 22, 23, 24, 2011, and June 4, 5, 6, 7, 8, 9, and 10, 2011. Medical record review revealed a nursing entry on June 3, 2011, referred to a resident fall on May 30, 2011. Review of the May 30, 2011, nursing notes revealed no documentation of a fall.

Interview with the administrator, in the administrator's office at 11:55 a.m., on September 21, 2011, verified the medical record did not reflect skilled nursing services documented for the resident for eleven days in May and seven days in June 2011.