### F 282: SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident’s written plan of care.

This REQUIREMENT is not met as evidenced by:

Intakes: TN00026118

Based on closed medical record review and interview, it was determined the facility failed to ensure the care plan was implemented for 1 of 24 (Resident #24) sampled residents.

The findings included:

Closed medical record review for Resident #24 revealed the resident was admitted to the facility on 8/21/09, and discharged on 8/25/09. Admission diagnoses included Spinal Stenosis - Lumbar, Hypercholesterolemia, Hypertension, Fracture Lumbar Vertebra - Closed and Aftercare Internal Fixation Device.

The admission care plan for Resident #24 included the following problems and interventions:

a. Problem of "Skin Impairment/Skin Risk/Surgical Wound" with a goal of "Skin Impairment/Skin Risk/Surgical Wound" and an intervention of, "Turn and reposition every 2 hours and as needed."

b. Problem of, "Altered Comfort Related to: Goal: Pain will be addressed and interventions will be effective." Interventions for this problem included,
### SUMMARY STATEMENT OF DEFICIENCIES

**F 282 Continued From page 1**

"Monitor for constipation with interventions as appropriate."

c. Problem of, "Constipation, Goal: Will have a bowel movement every 2- [to] 3 days."

Interventions for this problem included, "Monitor for bowel movements and record."

Closed medical record review revealed there was no documentation the resident was turned and repositioned every 2 hours or as needed, and no documentation for the resident's bowel movements.

In an interview in the Director of Nursing's (DON) office, on 1/13/11 at 8:30 AM, the DON confirmed there was no documentation of bowel movements found in Resident #24's chart.