F 226
SS=D
483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, policy review, and interview, the facility failed to thoroughly investigate an injury of unknown origin for one resident (#1) of five residents reviewed.

The findings included:

Resident #1 was admitted to the facility on November 1, 2010, with diagnoses including Myocardial Infarction, Pneumonia, and Dysphagia and discharged February 1, 2011.

Medical record review of the Minimum Data Set dated January 29, 2011, revealed the resident had long and short term memory problems and required extensive assistance of two persons for transfers and ambulation.

Medical record review of a Nurse's noted dated January 17, 2011, revealed, "private sitter notified this Nurse (patient had a scratch on bridge of nose and bruising under L(left) eye ...ADON (Assistant Director of Nursing) notified ..."
Medical record review of the Nurse’s note dated January 17, 2011, "...reported to me that this resident had a bruise on nose and Lt (left) side of face ... daughter at bedside...offered to send to ER and (daughter) declined stating have MD see (resident) in AM"

Medical record review of the X-ray report dated January 18, 2011, revealed "...Minimally displaced nasal bone fracture ...

Medical record review of the facility documentation dated January 16, 2011, revealed "...bruising noted under L(left) eye (and) nose ...pt(patient) has 24hr/day sitter 7 day/week ..."

Review of the facility abuse policy revealed "...All events reported as possible abuse, neglect or misappropriation of patient property will be investigated "

Telephone interview with Certified Nursing Assistant (CNA) #1 on March 24, 2011 at 3:37 p.m., confirmed on January 16, 2011, at approximately 4:00 p.m. the resident's private sitter reported the bruising and swelling to the resident's face, and CNA #1 reported this to the Charge Nurse.

Telephone interview with Licensed Practical
**Name of Provider or Supplier:**

**Holston Health & Rehabilitation Center**

**Address:** 3916 Boyds Bridge Pike, Knoxville, TN 37914

**Date Survey Completed:** 04/07/2011

<table>
<thead>
<tr>
<th>ID</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>Provider's Plan of Correction</th>
<th>Completion Date</th>
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<tbody>
<tr>
<td>F 226</td>
<td>Continued From page 2</td>
<td>Nurse #1 (on duty January 16, 2011, from 7:00 a.m. to 3:00 p.m.) on April 6, 2011, at 9:30 a.m., confirmed was interviewed by the Director of Nursing by telephone but denies knowledge of any reported falls or incidents. Telephone interview with CNA #2 (on duty January 16, 2011, from 7:00 a.m. to 3:00 p.m.) on April 6, 2011, at 9:40 a.m., denies any knowledge of any falls or incident with this resident. Telephone interview with private sitter #1 on April 6, 2011, at 11:10 a.m., was reported to sitter #1 on January 16, 2011, that the resident had a nose bleed on the evening of January 15, 2011, and did not note any bruising. Continued interview revealed on Monday January 17, 2011, bruising and swelling noted to face and the facility nurse was notified and also provider of the sitters was notified. Further interview confirmed sitter #1 denies any knowledge of any falls or incident with the resident. Telephone interview with sitter #2 on April 6, 2011, at 11:25 a.m., confirmed did note swelling and bruising to the face and nose on the afternoon of January 16, 2011, and this was reported to CNA #1. Telephone interview with sitter #3 on April 6, 2011, at 1:25 p.m., confirmed worked the evening of January 15, 2011, and no bruise or swelling noted to the face and confirms the resident had a</td>
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history of becoming agitated and combative, but denies any knowledge of any fall or incident.

Telephone interview with sitter #4 on April 7, 2011, at 10:55 a.m., revealed sitter #4 began to sit with the resident after the injury and has no knowledge of any fall or incident.

Telephone interview with the Director of Nursing on April 7, 2011, at 12:45 p.m., confirmed on January 16, 2011, bruising under left eye and swelling were noted to the nose, an x-ray was obtained on January 18, 2011, and revealed a nasal fracture. Continued interview confirmed, the resident received sitters 24 hours a day 7 days a week. Further interview confirmed no written statements were obtained from the previous night shift staff, the sitter service was notified, however the facility did not interview or obtain written statements from the sitters that cared for the resident, the investigation of the injury of unknown origin was not thorough, and the facility did not report the injury of unknown origin to the State Agency.

c/o 27655