<table>
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<tr>
<th>F 282</th>
<th>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</th>
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<tbody>
<tr>
<td>SS=G</td>
<td>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</td>
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This REQUIREMENT is not met as evidenced by:

Intakes: TN0031822

Based on medical record review and interview, it was determined the facility failed to provide weekly skin assessments as care planned to prevent and identify skin breakdown for 1 of 4 (Resident #3) sampled residents for pressure ulcers, which resulted in actual harm when Resident #3 was admitted to the hospital with stage 2 pressure sores that the facility failed to identify.

The findings included:

Medical record review for Resident #3 revealed an admission dated of 5/1/13 with diagnoses including Dementia with behavior disturbance, Congestive Obstructive Pulmonary Disease, Hypertension, Generalized muscle weakness, Gastro Esophageal Reflux Disease and History of Alcoholism. Review of Resident #3's care plan, documented a problem of "Potential for skin breakdown due to decreased mobility, frequently incontinent of B&B [bowel and bladder]..." and Approaches for this problem, "Weekly skin assessment..."

Review of the latest weekly nursing summary dated 5/25/13, included a skin assessment and...

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<tr>
<th>Laboratory Director's or Provider/Supplier Representative's Signature</th>
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<tbody>
<tr>
<td>David H. Slater</td>
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<tr>
<td>Title: Administrator</td>
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<tr>
<td>Date: 10/11/13</td>
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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 discloseable 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 discloseable 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.
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documented the only area of concern was left "2nd toe thick". The most recent wound assessment report prior to the weekly nursing summary of 5/25/13 was dated 5/15/13 and documented a pressure ulcer to the left ear.

Review of Resident #3's daily skilled nurses notes for 5/1/13 through 5/29/13 revealed a checklist on the front of each daily note which documented a checkmark for "Skin Color Normal". There was no checkmark for "Decubitus Wound" or for "Pressure Ulcer Management" on these daily notes.

Nurse's notes for Resident # 3 dated 5/29/13 documented, 1:00 PM, "Pt [patient] noted to have [decreased] appetite. Pocketing food and liquids. M.D. [Medical Doctor] notified @ [at] this time..." 6:45 PM, "Pt family requesting that pt be sent to ER [emergency room] for eval [evaluation]. States he's not his usual self. Order received to send to ER for eval. On call nurse notified. EMS [emergency management service] notified and here @ this time to transport to ER. Family @ side... VS [vital signs]: BP [blood pressure]: 120/78 P [pulse] 56 R [respiration] 18 T [temperature] 97.9."

Review of Resident #3's hospital records documented the resident arrived to the hospital on 5/29/13 at 6:12 PM. Presenting complaint was documented as, "...EMS states: pt sent from [named this facility]. Mobile X-ray showed pneumonia per EMS report. Pt has not been eating x [times] 2 days. To have consult tomorrow for feeding tube. Family concerned that he is not acting normally. Unable to obtain an initial BP either by manual or auto cuff. Temp 87.8..." Triage assessment completed at 8:01 PM.

Date of compliance: 10/11/13
**COUNTRYSIDE HEALTHCARE AND REHABILITATION**

<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>F 282</td>
<td>Continued From page 2: &quot;...Rash with fungal appearance on perineal area. Stage 2 decubitus on both buttocks. &quot; The physician's &quot;History and Physical&quot; dictated 5/30/13 documented, &quot;...The patient has multiple pressure ulcers. He has a stage 2 pressure ulcer on the right upper buttock. He has stage 3 ulcer on the left buttock... He has also a few more ulcers on both feet...&quot; During a telephone interview on 9/26/13 at 9:00 AM, the Director of Nursing stated she was not aware Resident #3 was assessed to have pressure ulcers at the hospital. During a telephone interview on 9/26/13 at 1:30 PM, the Administrator verified there were no other skin assessments documented after 5/25/13. The facility failed to complete weekly assessments as care planned. The failure to identify stage 2 pressures resulted in actual harm to Resident #3.</td>
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<td>F 314</td>
<td>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</td>
<td>F 314</td>
<td>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:</td>
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F 314  Continued From page 3

Based on medical record review and interview, it was determined the facility failed to provide weekly skin assessments as care planned to prevent and identify skin breakdown for 1 of 4 (Resident #3) sampled residents for pressure ulcers, which resulted in actual harm when Resident #3 was admitted to the hospital with stage 2 pressure sores that the facility failed to identify.

The findings included:

Medical record review for Resident #3 revealed an admission dated of 5/1/13 with diagnoses including Dementia with behavior disturbance, Congestive Obstructive Pulmonary Disease, Hypertension, Generalized muscle weakness, Gastro Esophageal Reflux Disease and History of Alcoholism. Review of Resident #3's care plan, documented Problem, "Potential for skin breakdown [due to] decreased mobility; frequently incontinent of B&B [bowel and bladder]..." and Approaches for this problem, "Weekly skin assessment...

Review of the latest weekly nursing summary dated 5/25/13, included a skin assessment and documented the only area of concern was left "2nd toe thick". The most recent wound assessment report prior to the weekly nursing summary of 5/25/13 was dated 5/15/13 and documented a pressure ulcer to the left ear.

Review of Resident #3’s daily skilled nurses notes for 5/1/13 through 5/29/13 revealed a checklist on the front of each daily note which documented a checkmark for "Skin Color Normal". There was no checkmark for "Decubitus Wound" or for "Pressure Ulcer Management" on these daily
Nurse's notes for Resident #3 dated 6/29/13 documented, 1:00 PM, "Pt [patient] noted to have [decreased] appetite. Pocketing food and liquids. M.D. [Medical Doctor] notified @ [at] this time..." 6:45 PM, "Pt family requesting that pt be sent to ER [emergency room] for eval [evaluation], States he's not his usual self. Order received to send to ER for eval. On call nurse notified. EMS [emergency management service] notified and here @ this time to transport to ER. Family @ side... VS [vital signs]: BP [blood pressure]: 120/78 P [pulse] 58 R [respiration] 16 T [temperature] 97.9."

Review of Resident #3's hospital records documented the resident arrived to the hospital on 5/29/13 at 6:12 PM. Presenting complaint was documented as, "...EMS states: pt sent from [named this facility], Mobile X-ray showed pneumonia per EMS report. Pt has not been eating x [times] 2 days. To have consult tomorrow for feeding tube. Family concerned that he is not acting normally. Unable to obtain an initial BP either by manual or auto cuff. Temp 87.8..."

Triage assessment completed at 8:01 PM documented, "...Rash with fungal appearance on perineal area. Stage 2 decubitus on both buttocks..." The physician's "History and Physical" dictated 6/30/13 documented, "...The patient has multiple pressure ulcers. He has a stage 2 pressure ulcer on the right upper buttock. He has stage 3 ulcer on the left buttock... He has also a few more ulcers on both feet..."

During a telephone interview on 9/26/13 at 9:00 AM, the Director of Nursing stated she was not aware Resident #3 was assessed to have

Date of compliance: 10/11/13
F 314 Continued From page 5

pressure ulcers at the hospital.

During a telephone interview on 9/26/13 at 1:30 PM, the Administrator verified there were no other skin assessments documented after 5/25/13.

The facility failed to complete weekly assessments as care planned. The failure to identify stage 2 pressures resulted in actual harm to Resident #3.