1200-8-(a)9.(xx) Records and Reports

(2) Unusual events shall be reported by the facility to the Department of Health in a format designed by the Department within seven (7) business days of the date of the identification of the abuse of a patient or an unexpected occurrence of accident that results in death, life threatening or serious injury to a patient.

(a) The following represent circumstances that could result in an unusual event that is an unexpected occurrence or accident resulting in death, life threatening or serious injury to a patient, not related to a natural course of the patient’s illness or underlying condition. The circumstances that could result in an unusual event include, but are not limited to:

9. procedure related incidents, regardless of setting and within thirty (30) days of the procedure and includes readmissions, which include:

(xx) patient abuse, patient neglect, or misappropriation of resident/patient funds;
This Rule is not met as evidenced by:
Intakes: TN0029446

Type C Pending Penalty #23

Tennessee Code Annotated 68-11-804(c)23: Incidents (such as a fire in the nursing home, burning of a patient, or an unusual accident that causes injury to a patient) shall be recorded, investigated within the facility, and reported pursuant to T.C.A. 68-11-211.

Based on policy review, medical record review, review of an alleged abuse allegation, review of inservice education report and interview, it was

The facility will report allegations of abuse to the state within 5 days of an alleged incident.

All residents were individually interviewed to determine if other allegations of abuse existed. No other residents were found to be affected.

Education regarding reporting allegations of abuse was provided. When an allegation of abuse is reported by another entity to the state, the Administrator will also report this allegation.

Allegations of abuse and timely reporting to the state will be tracked and monitored by the Administrator. Results will be presented to the facility QA&A Committee for review.
N1129. Continued From page 1
determined the facility failed to ensure an
allegation of abuse was reported to the state
agency within 5 days of the incident for 1 of 5
(Resident #1) sampled residents.

The findings included:

Review of the facility's "ABUSE, NEGLECT AND
MISAPPROPRIATION" policy documented,
"...The Administrator/designated person will make
an immediate report to the local Department of
Social Services and Licensing and Regulation
and other designated agencies and local law
enforcement as required regarding an allegation
of abuse, mistreatment..."

Medical record review for Resident #1
documented an admission date of 3/18/11 with
diagnoses of Parkinson's Disease, Hypertension,
Gastroesophageal Reflux Disease, chronic
Kidney Disease, Depressive Disorder, Muscle
Weakness and Dysphagia.

Review of the facility's "INVESTIGATION
SUMMARY - CONFIDENTIAL" dated 2/27/12
documented, "...Cause to initiate Investigation...
Resident [#1] was sent to ER [Emergency Room]
via ambulance D/T [due to] [right] shoulder pain -
Told Dr. [Doctor] in ER that staff hurt her - ER Dr.
called APS [Adult Protective Services]..."

Review of the "IN-SERVICE EDUCATION
REPORT" dated 2/26/12 documented, "Number
of Employees Present: See Attached... Subject
Content (attach copies of handouts); See
Attached... Federal Regulation... The facility must
report all alleged violations and all substantiated
incidents to the state agency and to all other
agencies as required..." as information that was
provided to staff in their inservice.
During an interview in the lobby on 3/15/12 at 11:00 AM, the Administrator was asked if he had reported this alleged abuse allegation to the state. The Administrator stated, "...No, I did not realize it should have been reported..."

During an interview in the marketing office on 3/15/12 at 11:20 AM, the Director of Nursing stated, "...Because we investigated it and determined it was not abuse, did not think we had to report it [alleged abuse allegation]..."