DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDERS/SUPPLIER/OLA IDENTIFICATION NUMBER: 445457

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
11/18/2010

STREET ADDRESS, CITY, STATE, ZIP CODE
468 ISBLL RD
MADISONVILLE, TN 37354

NAME OF PROVIDER OR SUPPLIER
EAST TENNESSEE HEALTH CARE

ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES | ID PREFIX TAG | PROVIDERS PLAN OF CORRECTION | ID COMPLETION DATE
--- | --- | --- | --- | ---
F 000 | INITIAL COMMENTS | F 000 | | 

An annual Recertification and complaint investigation #s 26549 and 26665 were completed at East Tennessee Health Care on November 16-18, 2010. No deficiencies were cited related to complaint investigation #s 26549 and 26665 under 42 CFR Part 482.13, Requirements for Long Term Care Facilities.

483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative, and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, the facility failed to revise the care plan for two residents (#3, and #8) of fifteen residents reviewed.

LAWYER DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

DATE

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 required to continued program participation.
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<th>Summary Statement of Deficiencies</th>
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<th>Provider's Plan of Correction</th>
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<tbody>
<tr>
<td>F 280</td>
<td>Continued From page 1</td>
<td></td>
<td>The findings included:</td>
<td>F 280</td>
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<td>Resident #3 was admitted to the facility on September 13, 2007, with diagnoses including Dementia, Diabetes, and Osteoarthritis.</td>
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<td>Medical record review of the Physician Orders for Scope of Treatment (POST) form, signed by the resident's Power of Attorney (POA) on August 6, 2010, revealed &quot;...Do Not Attempt Resuscitate (DNR/no CPR)...&quot;</td>
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<td>Medical record review of the Plan of Care dated September 25, 2010, revealed &quot;...In event of cardiorespiratory failure, Begin CPR...&quot;</td>
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<td>Interview on November 16, 2010, at 1:45 p.m., with the Minimum Data Set Coordinator, in the conference room, confirmed the Plan of Care dated September 25, 2010, was not revised to indicate the DNR status.</td>
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<td>Resident #8 was admitted to the facility on April 4, 2005, with diagnoses including Hypertension, Dementia, Cardiac Dysrhythmia, Diabetes Mellitus, Osteoarthritis, Anemia, Depression, Psychosis and Anxiety.</td>
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<td>Medical record review of a Pre-Restraint Assessment dated August 3, 2010, and updated October 19, 2010, revealed the resident as having &quot;...bed/chair alarm...&quot;</td>
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<td>Medical record review of the Care Plan updated October 19, 2010, revealed no documentation a bed/chair alarm was required.</td>
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<td>Observation on November 16, 2010, at 9:30 a.m.,</td>
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</table>
STATEMENT OF DEFIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA
IDENTIFICATION NUMBER:

445467

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED

11/18/2010

NAME OF PROVIDER OR SUPPLIER

EAST TENNESSEE HEALTH CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
405 ISBILL RD
MADISONVILLE, TN 37354

(X4) ID
PREFIX
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SUMMARY STATEMENT OF DEFIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

F 280
Continued From page 2
and 1:30 p.m., revealed the resident seated in a
wheelchair at the bedside with a personal safety
alarm attached.

Interview with the ADON (Assistant Director of
Nursing), on November 17, 2010, at 10:35 a.m.,
confirmed the resident was to have a personal
alarm in place when in the bed or chair.

Interview with the Care Plan Coordinator on
November 17, 2010, at 1:45 p.m., confirmed the
Care Plan had not been updated to reflect the
addition of the personal alarm.

F 323
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 by:

Based on medical record review, observation,
and interview, the facility failed to ensure safety
devices were in place for three residents (#6, #13,
and #8) of fifteen residents reviewed.

The findings included:

Resident #6 was admitted to the facility on
January 14, 2009, with diagnoses including
Dementia, Diabetes, Osteoporosis, and
Depression.

ID
PREFIX
TAG

F 280
F 323

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCE TO THE APPROPRIATE
DEFICIENCY)

F 323 483.25(h)
SS-D

Free of Accident Hazards/SuperVision/Devices

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

Corrective Actions:
1a. On 11/16/2010 the DON reviewed care plan of
   Resident #6 to ensure compliance with "Mobility Alarm
   when in bed and chair" and applied alarm as ordered.
1b. On 11/17/2010 the DON reviewed care plan of
   Resident #13 to ensure compliance with "alarm to be
   on and working when in bed and in chair" and
   applied alarm as ordered.
2c. On 11/17/2010 the DON reviewed care plan of
   Resident #8 to ensure compliance with
   "Having bed/chair alarm" and applied alarm as ordered.
   performed audit of care plans and resident care sheets
to ensure compliance with bed/chair alarms.
   performed audit of care plans and CNA resident care
   sheets to ensure compliance with bed/chair alarms.
   performed audit of Pre-Restraint Assessments to
   ensure compliance with bed/chair alarms.
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</table>
| F 323  | Continued From page 3
Medical record review of the Minimum Data Set (MDS) dated October 7, 2010, revealed the resident required limited assistance with transfers and ambulation.  
Medical record review of a Fall Risk Assessment dated October 8, 2010, revealed the resident was at moderate risk for falls.  
Medical record review of the Plan of Care dated October 8, 2010, revealed "...Risk for falls/injury...Mobility alarm when in bed & chair..."  
Observation on November 16, 2010, at 9:10 a.m., revealed the resident seated in a wheelchair, in the hallway, without a mobility/safety alarm in place.  
Observation and interview on November 16, 2010, at 9:17 a.m., with Licensed Practical Nurse (LPN) #1, revealed the resident sitting in the wheelchair, in the hallway, and confirmed the mobility/safety alarm was not in place.  
Resident #13 was admitted to the facility on September 25, 2007, with diagnoses including Alzheimer's Disease, Osteoarthritis, and Hypertension.  
Medical record review of the MDS dated July 7, 2010, revealed the resident had severely impaired cognitive skills, and required extensive assistance with transfers and walking.  
Medical record review of a Fall Risk Assessment dated August 25, 2010, revealed the resident was at high risk for falls.  
Medical record review of the Plan of Care dated July 8, 2010, revealed "...At risk for injury...Alarm

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<th>F 323 483.25 (n) con't from page 3 of 6</th>
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4. The facility DON, Risk Management, and/or Designee will audit resident charts q daily in Leadership morning meeting for compliance with bed/chair alarm/mobility alarm procedures. DON, Risk Management, and/or Designee will audit weekly q three months until compliance is achieved.  
If compliance is not achieved DON will re-inservce and resume weekly audits until substantial compliance is met. Audit findings will be reviewed monthly in the Fall/Rasstraint Meeting and quarterly in QA & QI Meeting. |
<p>|        | 12/03/2011                                                                          |</p>
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<td>Medical record review of the Minimum Data Set (MDS) dated October 7, 2010, revealed the resident required limited assistance with transfers and ambulation. Medical record review of a Fall Risk Assessment dated October 8, 2010, revealed the resident was at moderate risk for falls. Medical record review of the Plan of Care dated October 8, 2010, revealed &quot;...Risk for falls/injury...Mobility alarm when in bed &amp; chair...&quot; Observation on November 16, 2010, at 9:10 a.m., revealed the resident seated in a wheelchair, in the hall, without a mobility/safety alarm in place. Observation and interview on November 16, 2010, at 9:17 a.m., with Licensed Practical Nurse (LPN) #1, revealed the resident sitting in the wheelchair, in the hallway, and confirmed the mobility/safety alarm was not in place. Resident #13 was admitted to the facility on September 25, 2007, with diagnoses including Alzheimer's Disease, Osteoarthritis, and Hypertension. Medical record review of the MDS dated July 7, 2010, revealed the resident had severely impaired cognitive skills, and required extensive assistance with transfers and walking. Medical record review of a Fall Risk Assessment dated August 25, 2010, revealed the resident was at high risk for falls. Medical record review of the Plan of Care dated July 8, 2010, revealed &quot;...At risk for injury...Alarm</td>
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<td>F 323</td>
<td>483.25</td>
<td>3. On 11/22 &amp; 30/2010, and 12/3/2010, the DON interviewed licensed and certified nursing staff on bed/chair alarm/mobility alarm procedures. On 12/07/2010 DON interviewed ADON, Risk Mgt. Nurse and Staffing Coordinator on facility rounds to ensure compliance per personal alarms/care plans. DON, ADON, Risk Mgt. Nurse and Staffing Coordinator will ensure bed/chair alarms are in place and functioning properly during daily rounds Monday thru Friday. In absence of Nurse Mgt., Facility Charge Nurse will monitor placement and function of bed/chair alarms and document on resident MAR daily/shift. Maintenance Supervisor and/or designee will ensure compliance with bed/chair alarms q weekend per placement and function of bed/chair alarms. 4. The facility DON, Risk Management, and/or Designee will audit resident charts q daily in Leadership morning meeting for compliance with bed/chair alarm/mobility alarm procedures. DON, Risk Management, and/or designee will audit weekly q three months until compliance is achieved. If compliance is not achieved DON will re-inservce and resume weekly audits until substantial compliance is met. Audit findings will be reviewed monthly in the Fall Restraint Meeting and quarterly in QA &amp; QI Meeting. 12/22/2010</td>
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</tbody>
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**F 323** Continued From page 4
to be on and working when in bed and in chair..."

Medical record review of a Nurse's Event Note dated August 25, 2010, at 9:15 a.m., revealed "...Walked in to find resident setting in floor. No apparent injury...Immediate Steps Implemented to Prevent Recurrence. All alarms to be on...when in chair and in bed..."

Observation on November 17, 2010, at 2:25 p.m., revealed the resident lying on the bed with a safety alarm in place.

Interview on November 17, 2010, at 3:15 p.m., with the Assistant Director of Nursing, in the nursing office, confirmed the safety alarm was not in place at the time of the fall on August 25, 2010.

Resident #8 was admitted to the facility on April 4, 2005, with diagnoses including: Hypertension, Dementia, Cardiac Dysrhythmia, Diabetes Mellitus, Osteoarthritis, Anemia, Depression, Psychosis and Anxiety.

Medical record review of the Pre-Restraint Assessment, dated August 3, 2010 and updated October 19, 2010, revealed the resident as having "...bed/Chair alarm..."

Observation on November 17, 2010, at 9:35 a.m., revealed the resident sitting up in a wheelchair at the bedside. The personal safety alarm was lying in a recliner behind the resident's wheelchair, not attached to the resident.

Observation and interview on November 17, 2010, at 9:45 a.m., with LPN (Licensed Practical Nurse) #3, revealed the resident seated in a
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<td>F 323</td>
<td>Continued From page 5 wheelchair, and confirmed a chair alarm was to be used when the resident was seated in the wheelchair. Continued interview with LPN #3 confirmed the personal safety alarm was not attached to the resident.</td>
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465 ISBELL RD

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