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<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
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<tr>
<td>F 221</td>
<td>SS=D 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RERAINTS</td>
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The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, facility policy review, observation, and interview, the facility failed to assess the use of a restraint for one resident (8) of eighteen residents reviewed.

The findings included:

Resident #8 was admitted to the facility on October 16, 2008, with diagnoses including End Stage Renal Disease, Peripheral Vascular Disease, and Diabetes. Medical record review of the Minimum Data Set dated September 10, 2010, revealed the resident had short/long term memory problems with moderately impaired cognitive skills for daily decision making.

Medical record review of the current Care Plan dated June 2010 revealed, "...Self Release Alarm Belt in wheelchair..."
F 000 INITIAL COMMENTS

An annual Recertification survey and complaint investigation #269856 were completed on November 29, 2010, through December 1, 2010, at Sweetwater Nursing Center. No deficiencies were cited related to complaint investigation #269856 under 42 CFR PART 482, Requirements for Long Term Care Facilities.

F 221 483.13(a) RIGHT TO BE FREE FROM PHYSICALRAINTRAINTS

The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident’s medical symptoms.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, facility policy review, observation, and interview, the facility failed to assess the use of a restraint for one resident (#8) of eighteen residents reviewed.

The findings included:
Resident #8 was admitted to the facility on October 16, 2006, with diagnoses including End Stage Renal Disease, Peripheral Vascular Disease, and Diabetes. Medical record review of the Minimum Data Set dated September 10, 2010, revealed the resident had short term memory problems with moderately impaired cognitive skills for daily decision making.

Medical record review of the current Care Plan dated June 2010 revealed, "...Self Release Alarm Belt in wheelchair..."
Continued From page 1

Medical record review revealed an assessment for the use of the restraint had not been completed.

Review of facility policy Restraint, Physical revealed "...The Resident must be physically and cognitively able to self-release devices... seat belts with Velcro, or easy snap seat belts. If a resident cannot mentally and physically self-release, then the device is considered a restraint..."

Observation with the Director of Nursing, on November 30, 2010, at 9:00 a.m., revealed the resident in the hall seated in a wheelchair with a self release belt in place. Further observation revealed the resident was not able to release the seat belt when asked by the Director of Nursing.

Interview on November 30, 2010, at 9:00 a.m., in the hall, with the Director of Nursing, confirmed an assessment for the use of the self release belt had not been completed.

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:

F 221 Continued

F 315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER
F 315  Continued From page 2
Based on medical record review, observation, facility policy review, and interview, the facility failed to provide a bladder training program for one resident (#3) of eighteen residents reviewed.

The findings included:

Resident #3 was readmitted to the facility on September 20, 2010, with the diagnosis of Subarachnoid Hemorrhage. Medical record review of the Minimum Data Set dated June 13, 2010, revealed the resident had short/long term memory deficits and moderate cognitive impairment. Continued medical record review revealed the resident’s transferral with supervision, required limited assistance with ambulation, and was occasionally incontinent of bladder.

Medical record review of the Minimum Data Set (MDS) dated September 26, 2010, revealed the resident had a significant change of status after sustaining a fall with a head injury on September 18, 2010. Continued medical record review revealed the resident’s cognition had not changed from the MDS assessment dated June 13, 2010. Further medical record review revealed the resident had a decline in ability to perform activities of daily living, required extensive assistance with transfers, was non-ambulatory, and was always incontinent.

Medical record review of an evaluation for bowel and bladder retraining and progress notes dated October 8, 2010, revealed "...Resident is unable to participate in retraining efforts of bladder due to cognitive status and functional limitations..."

Continued medical record review revealed "...SCSA (significant change status assessment) -
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<td>F 315</td>
<td>Continued From page 3. Will attempt to reduce urinary incontinence by routinely offering and assisting res (resident) to toilet, promptly assisting as res requests... Review of facility policy Bladder Retraining revealed the objective was to restore the residents' ability to control urination. Observation on November 29, 2010, at 8:40 a.m., revealed the resident sitting in bed, alert, and convulsive. Continued observation revealed the resident was able to demonstrate use of the call light to alert staff. Interview with the Charge Nurse at the 400 hall nurses station on December 1, 2010, at 10:20 a.m., confirmed the resident was able to make toileting needs known, including when incontinence had occurred, and required assistance from staff for transfers to the toilet and incontinence care. Interview with the Director of Nursing in the day room on December 1, 2010, at 12:30 p.m., confirmed the resident had experienced a decline in urinary continence, would be a good candidate for bladder retraining, and a voiding pattern had not been established for the resident to facilitate an individualized toileting plan to improve incontinence.</td>
<td>F 315</td>
<td>The facility believes its current practices were in compliance with the applicable standard of care, but that in order to respond to this citation from the surveyors, the facility is taking the following additional actions:........... F371 Corrective Action: In-service has been conducted by Dietary Manager with all Dietary Staff on 12-3-10 regarding required procedures for sanitation of pots and pans in the three compartment sink. Sign was posted on 11-30-10 to serve as a reminder of the required sanitation time for pots and pans. Identification: Pots and pans shall be sanitized in the three compartment sink using the required solution for 60 seconds in order to ensure required compliance. Measures/Systematic Changes: Staff was inserviced on 11-30-10 and 12-3-10 by Dietary Manager on the correct way to utilize the sanitation process. This process will be added to orientation for new hires.</td>
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<td>F 371</td>
<td>483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</td>
<td>F 371</td>
<td>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions.</td>
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This REQUIREMENT is not met as evidenced by:
Based on observation, review of the manufacturer's reference sheet, and interview, the facility failed to ensure cooking utensils washed received adequate immersion time in the sanitizer to effect sanitization for one of one three compartment sink.

The findings included:

Observation in the kitchen on November 29, 2010, at 8:25 a.m., revealed dietary aide #1 washing pots, pans, and baking sheets in the three compartment sink. Continued observation revealed the dietary aide washed, rinsed, and dipped the items in the sanitizer briefly before placing them on the rack to air dry.

Observation of dietary aide #2 in the kitchen using the three compartment sink on November 30, 2010, at 11:25 a.m., revealed dietary aide #2 washed, rinsed, and swished several serving utensils in the sanitizing solution for 20 seconds before placing them on the rack to dry.

Review of the manufacturer's reference sheet recommendations for sanitization revealed "...To sanitize pre-cleaned mobile items in public eating establishments (drinking glasses, dishes, eating utensils) immerse in a 200 ppm (parts per million) active quaternary solution for at least 60 seconds making sure to immerse completely..."
**NAME OF PROVIDER OR SUPPLIER**

SWEETWATER NURSING CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

978 HWY 11 SOUTH

SWEETWATER, TN 37874

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<td>F 371</td>
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<td>F 502</td>
<td>SS=D PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY</td>
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The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

This **REQUIREMENT** is not met as evidenced by:

Based on medical record review and interview the facility failed to obtain lab work for one resident (#3) of eighteen residents reviewed.

The findings included:

Resident #3 was admitted to the facility on October 28, 2008, with diagnoses including Late Effects CVA (cerebrovascular accident), Alzheimer's Disease, Hypothyroidism, and Hypertension.

Medical record review of a Physician's Order dated November 4, 2010, revealed "...CBC (complete blood count) and BMP (basic metabolic panel) in 2 wks (weeks) 11/18/10..." Medical record review of the resident's lab results revealed no results were found for the date ordered.

Interview with the Assistant Director of Nursing in the day room on December 1, 2010, at 9:40 a.m., confirmed the lab work had not been obtained in November as ordered.

The facility believes its current practices were in compliance with the applicable standard of care, but that in order to respond to this citation from the surveyors, the facility is taking the following additional actions:

**Corrective Action:**

Resident #3 had a BMP and CBC collected on 11-29-10. Results faxed to MD. No further orders.

**Identification:**

Residents with lab orders have the potential to be affected.

**Measures/Systematic Changes:**

100% chart audit performed by the D.O.N./A.D.O.N. for lab orders and results from the last three months. Lab logs developed that include lab work ordered, date drawn, date returned, date MD signed, and date signed that the lab was filed in the medical record, have been placed at each nurses station. Licensed nurses will be in-serviced on maintaining the lab logs by the D.O.N. and/or the A.D.O.N. on 12-17-10, 12-22-10, 1-7-11, and 1-13-11.
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<td>F502 (continued)</td>
<td>Monitor/O.A.: Charge nurses will submit copies of lab results to the D.O.N./A.D.O.N. weekly. Lab logs will be reviewed and charts audited weekly for accuracy. Cumulative monthly reports will be presented by the D.O.N./A.D.O.N. to the facility’s Performance Improvement Committee (Administrator, D.O.N., A.D.O.N., Social Services, Admissions/Marketing Director, Dietary Manager, M.D.S. Coordinator, R.N. Assessment Nurse, Medical Records Clerk, Activity Director, Medical Director, and Pharmacy Consultant) for review and determination of ongoing compliance.</td>
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<td>Completion Date: January 14, 2011</td>
<td>1/14/11</td>
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