STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA
IDENTIFICATION NUMBER:
445508

(X2) MULTIPLE CONSTRUCTION
A. BUILDING:

B. WING:

(X3) DATE SURVEY
COMPLETED:
C 01/07/2013

NAME OF PROVIDER OR SUPPLIER

OBION COUNTY NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
1084 EAST COUNTY HOME ROAD
UNION CITY, TN 38261

(X4) ID
PREFIX
TAG
F 225
SS=D

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

483.13(c)(1)(ii)-(iii), (c)(2) - (4)
INVESTIGATE/REPORT
ALLEGATIONS/INDIVIDUALS

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

LABORATORY 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 requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete
Event ID: NKS811
Facility ID: TN6802
If continuation sheet Page 1 of 2
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**Continued From page 1**

This REQUIREMENT is not met as evidenced by:

Intakes: TN00030993

Based on interview, it was determined the facility failed to report to the state survey and certification agency an allegation of abuse within 5 working days of the allegation for 1 of 3 allegations of abuse reviewed.

The findings included:

During an interview in the conference room on 1/7/13 at 10:10 AM, the Administrator was asked if the allegation of abuse on 8/14/12 had been reported to the state during the time of the original report. The Administrator stated, "...to my knowledge, it was never reported to the state...it was investigated but not reported until that date [1/4/13]..."

During an interview in the conference room on 1/7/13 at 4:00 PM, the Director of Nursing (DON) was asked if the allegation on 8/14/12 had been reported to the state. The DON stated, "No, I thought it didn't have to be reported if not validated until Friday when the lady from APS [Adult Protective Services] was here..."