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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  

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<tr>
<th>(X4) ID</th>
<th>(X8) ID</th>
<th>PROVIDER/SUPPLIER IDENTIFICATION NUMBER</th>
<th>(X8) DATE SURVEY COMPLETED</th>
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<td>F 000</td>
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<td>445363</td>
<td>08/10/2011</td>
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NAME OF PROVIDER OR SUPPLIER  
STANDING STONE CARE AND REHAB  

STREET ADDRESS, CITY, STATE, ZIP CODE  
410 W CRAWFORD AVENUE  
MONTEREY, TN 38574  

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<tr>
<th>(X4) ID</th>
<th>(X8) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSSEXERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X8) COMPLETION DATE</th>
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| F 000   | F 000   | INITIAL COMMENTS  
During the complaint investigations TN0028167 and TN0028141, completed on August 6-10, 2011, no deficiencies were cited with Part 483 Requirements for Long Term Care Facilities.  

F 281  
SSD  
483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  
The services provided or arranged by the facility must meet professional standards of quality.  

This REQUIREMENT is not met as evidenced by:  
Based on medical record review, observation, and interview, the facility failed to follow a physician's order for one (#7) of nineteen residents reviewed.  
The findings included:  
Resident #7 was admitted to the facility on August 4, 2011, with diagnoses including Respiratory Failure, Tracheostomy (artificial airway in the throat), and Diabetes.  

Medical record review of the physician's admission orders dated August 4, 2011, revealed "...Aspiration Precautions assist with all meals..."  
Observation on August 9, 2011, at 8:00 a.m., in the resident's room revealed the breakfast tray on the over bed table and the resident eating, with no staff present in the room.  
Observation and interview, on August 9, 2011, at 12:45 p.m., in the resident's room revealed a bowl of chocolate pudding on the over bed table.  

1. Corrective action for residents affected:  
Resident # 7 was assessed for any signs or symptoms of aspiration by nursing management with none noted on 8/10/11. MD for resident # 7 was notified on 8/10/11 of resident not being assisted with p.o. and no changes were made with orders at this time. Staff working with resident # 7 has been educated on assisting this resident with p.o. intake. Speech therapy will continue with resident #7 and teaching given to staff as needed. SS and nursing to monitor for any signs or symptoms of fear related to condition and assistance will be given as needed.  

2. Identification of residents having the potential to be affected:  
On 8/10/11 Residents with diagnosis of risk of aspiration were assessed to ensure condition stable and no complications noted with p.o. intake. Care plans for these residents were reviewed to ensure interventions in place to prevent aspiration.  

LABORATORY DIRECTORS AT PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  

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.) Excep 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 90 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-2587 (02-09) Previous Versions Obsolete  
Event ID: BDTS11  
Facility ID: TN7104  
If continuation sheet Page 1 of 6
**STANDING STONE CARE AND REHAB**

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| TAG       | Continued From page 1 | Interview with resident #7 revealed the resident had just finished lunch. Continued interview revealed staff did not stay in the resident's room while the resident ate meals.

Observation on August 10, 2011, at 7:50 a.m., in the resident's room revealed the breakfast tray on the over bed table with 70% of the meal remaining, and the resident had pushed the table away, indicating the resident was finished eating breakfast. Continued observation revealed no staff in the room.

Interview on August 10, 2011, at 8:10 a.m., with the Speech Therapist (ST) at the 300/400 hallways nurse's desk confirmed the physician order dated August 4, 2011, stated the resident required assistance with meals. Continued interview revealed the ST evaluated the resident on August 9, 2011, for safe eating, the resident had some difficulty with swallowing due to the trach and the resident was afraid to eat without someone present if the resident choked.

Interview on August 10, 2011, at 8:20 a.m., with the resident, in the resident's room, confirmed no staff stayed in the resident's room during meal time, the resident was afraid of choking, and wanted someone in the room while the resident was eating.

Interview on August 10, 2011, at 8:30 a.m., near the 300/400 hallways nurse's desk with Licensed Practical Nurse #2, confirmed the physician's order was not followed.

**483.20(i)(3) ANTICIPATE DISCHARGE POST-DISCHARGE PLAN**
**Requirement F264**

Continued from page 2

When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.

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

- Based on medical record review, review of facility policy, and interviews, the facility failed to address urinary catheter care on the post discharge plan of care for one resident (#19) of three closed records reviewed.

The findings included:

- Resident #19 was admitted to the facility on May 16, 2011, with diagnoses including Late Effects of Cerebrovascular Disease with Hemiplegia, Benign Prostatic Hypertrophy, Urinary Retention, and Muscle Weakness. The resident was discharged to home on July 22, 2011.

Medical record review of the Minimum Data Set with an assessment reference date of May 16, 2011, revealed a score of fifteen (highest possible total score) on the Brief Interview for Mental Status indicating the resident was cognitively intact.

Medical record review of a Daily Skilled Nurse's Note dated July 22, 2011, revealed "...Res. (resident) discharged home with 30 day supply of meds to...(name and location of pharmacy). Leg bag applied to (name) catheter. Left via private vehicle in stable condition..." Continued review of

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<td>8/11/11</td>
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<tr>
<td>1. Corrective action for residents affected:</td>
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<td>On 8/10/11 family of resident #19 was contacted to ensure knowledge of use of catheter/leg bag. Family stated that charge nurse on duty had instructed them on how to change leg bag to bedside bag, on draining bags, on signs and symptoms of infection and why bag might not be draining properly, how to prevent contamination and infections. Family verbalized understanding of teaching given. Staff Development Coor. and DON began in-service with nurses on 8/11/11 related to discharge teaching and documentation of teaching given to residents and families.</td>
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<td>2. Identification of residents with potential to be affected:</td>
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<td>Charts for residents with planned discharges within next 30 days were audited on 8/11/11 and discharge teaching plans will be set up as indicated for resident and their families according to needs for day of discharge. Records for residents with planned discharges will be reviewed prior to discharge and discharge meeting set up with family with educational information to be prepared and given to family/caregiver during meeting. ADON/DON will review discharge charts on day of discharge to ensure compliance with facility discharge planning policy.</td>
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Daily Skilled Nurse's Notes dated July 15-21, 2011, revealed no documentation of catheter care teaching to the resident or other caregiver.

Medical record review of the "Discharge Instructions For Care" dated July 22, 2011, revealed no documentation of instructions regarding (name) catheter care.

Review of the facility policy and procedure "Discharge Planning" revealed "...Resident education is a major focus of discharge planning activities for all residents. Many resident's after care needs are met through education provided by each member of the healthcare team. Resident education includes, but is not limited to, information about: The anticipated need for continued care following discharge..."

Review of the facility policy and procedure "Resident Discharge" revealed "...If the resident is discharged to his/her home, a Home Care Instruction Sheet will be completed and reviewed with the family/responsible person..."

Interview on August 9, 2011, at 4:30 p.m. with the DON (Director of Nursing) in the DON's office, and on August 10, 2011, at 9:15 a.m., with the Administrator in the Administrator's office, confirmed the facility had failed to address (name) catheter teaching prior to discharge and had not included the same in the discharge instructions for this resident.

The facility must maintain clinical records on each
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<td>resident in accordance with accepted professional</td>
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<td>standards and practices that are complete;</td>
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<td>accurately documented; readily accessible; and</td>
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<td>systematically organized.</td>
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The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
- Based on medical record review, observation, facility policy review, and interview, the facility failed to maintain a complete and accurate medical record for one resident (#16) of nineteen residents reviewed.

### The findings included:

- Resident #16 was admitted to the facility on August 24, 2008, with diagnoses including Urinary Retention and Neurogenic Bladder.

- Medical record review of the care plan dated April 21, 2011, revealed, "...Provide catheter care as ordered by MD (Medical Doctor)."

- Medical record review of the physician's recapitulation orders dated May 1 through August 31, 2011, revealed no orders for catheter care.

- Medical record review of the Medication Administration Records (MAR's), Treatment Administration Records (TAR's), and CNA-ADL

### F 514

1. Corrective action for residents affected:

On 8/10/11 the medical record of resident # 16 was reviewed and updated to include documentation for cath care per MD order and per facility policy on facility treatment sheet for BID and as needed. MD was notified with no changes made to plan of care at this time. On 8/10/11 in-service was initiated for nursing staff on policy related to cath care and procedure of reporting cath care to charge nurse as completed and procedure would then be documented by nurse at that time. Care plan for resident #16 was reviewed on 8/10/11 and updated to ensure appropriate interventions in place for cleaning of catheter.

2. Identification of residents with potential to be affected:

Medical records for residents who have catheters were reviewed and updated to include documentation for cath care per MD order and policy on facility treatment sheet for BID and as needed. Care plans for these residents were updated to ensure appropriate interventions are in place for cleaning of catheter. ADON/DON will review monthly orders to ensure that all residents requiring catheters have appropriate orders for cath care and have been placed on monthly orders and processed as indicated.
Tracking Forms (Certified Nursing Assistant-Activities of Daily Living Tracking Forms) dated May 1 through August 31, 2011, revealed no documentation of catheter care.

Observation in the resident's room on August 9, 2011, at 2:50 p.m., revealed the resident lying on the bed with an indwelling catheter attached to bedside drainage.

Review of the facility's "Polex Catheter Care" policy and procedure dated December 2010, revealed, "...Guideline...It is the policy of this facility that catheter care will be provided to all residents with indwelling catheters at least twice daily and more often as needed..."

Review of the facility's "Catheter Care-Indwelling" policy and procedure dated December 2010, revealed, "...Procedural Guidelines...13. Chart procedure and any pertinent information..."

Interview with CNA #1 on August 9, 2011, at 3:30 p.m., at the 100 Hall Nurse's Station confirmed catheter care was not being documented.

Interview with the Director of Nursing (DON) on August 9, 2011, at 3:45 p.m., in the DON's office confirmed catheter care was to be completed twice daily and as needed, and document the completed procedure on the TAR's. Continued interview with the DON confirmed the facility did not document catheter care once completed and failed to maintain a complete and accurate medical record for this resident.

3. Measures to prevent reoccurrence:

Medical records for residents requiring catheters will be reviewed weekly, 4 weeks by ADON/DON to ensure proper documentation is being performed and then monthly following this time frame. DON will perform a 10% chart audit monthly on residents with catheters to ensure compliance with action plan. On 8/10/2011 in-service was initiated for nursing staff on policy related to cath care and procedure of reporting cath care to charge nurse as completed and procedure would then be documented by nurse at that time. New nursing employees will be in-serviced in orientation, annually and as needed on policy related to cath care and documentation of cath care on treatment sheet.

4. Monitoring of corrective action:

Findings from weekly audits will be reported during the weekly at risk meeting for follow-up. Audits and follow-up will be forwarded to the QA committee for review and recommendations on a quarterly basis. Performance improvement plans will be developed and education given as needed.