F 000 INITIAL COMMENTS

During complaint investigation of complaints #TN00026126, TN00026527, and TN00026680, conducted on October 4-19, 2010, at Smith County Health Care Center, no deficiencies were cited in relation to Complaint #TN00026126 under 42 CFR, PART 482.13, Requirements for Long Term Care.

F 226 DEVELOP/IMPLEMENT ABUSE/NEGLIGENCE, ETC POLICIES

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, review of facility investigation, facility policy review, and interview, the facility failed to complete a timely and thorough investigation of an injury of unknown source for one resident (#6) of eleven residents reviewed.

The findings included:

Resident #6 was admitted to the facility on August 31, 2007, with diagnoses to include Down's Syndrome, Gastroesophageal Reflux Disease, Ventricular-septal Defect, Hypertension, and Atrial-septal Defect. Review of the Minimum Data Set (MDS) dated September 13, 2010, revealed the resident had moderately impaired cognition but could answer simple yes/no questions; was independent with Activities of Daily Living (ADLs); was independent with eating, transfers, and ambulation.

F 226

This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

F 226

The facility has written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property that are implemented.

The resident found to be affected was identified as resident #6. No harm was noted to resident #6. This resident was discharged to another health care facility and the record was closed.

No other residents were found to be affected. Residents most at risk of abuse may include but is not limited to residents who have dementia, residents with no or infrequent visitors, residents with psychosocial and/or behavior issues and residents who are bedfast and totally dependent on care.

Injuries of unknown source will be reported and investigated in accordance with the facility's policy. The DNS will report all future allegations of abuse and the results of investigation to the Administrator.

A review of each investigation of any future occurrences will be accomplished by the Administrator.

Staff will receive education by the SDC and/or licensed nurse on "Appropriate Interventions to deal with challenging "behavior residents" and "How to report..."

Medical record review of a Behavior Monitoring Log dated July 25, 2010, revealed "Hitting self and furniture in room with hands. Laying down on bed; picking up legs with hands on thighs and slamming legs on bed. When standing up, pounding on sides and buttocks. Was told to stop - that behavior was not acceptable and could cause harm. Then resident sat down on bed; grabbed both inner thighs; and slammed legs down on bed."

Medical record review of a nursing note dated July 31, 2010, revealed "Multiple bruises to bilateral thigh area. Bruises appear to be healing. Attempted to notify brother. Message left."

Review of a facility event report dated July 31, 2010, revealed "...Injury of unknown source...Injury to self...hits self...circumstances unknown...bruise...bilateral thigh..." Continued review revealed the DON was unaware of the bruising since the DON had been out of town from July 31, to August 3, 2010, and scheduled a meeting with the resident’s brother for August 3, 2010, to review concerns expressed by the brother.

Continued review revealed during the meeting the resident was brought to the DON’s office and on examination the DON noted a large pale green bruised area on the left anterior thigh with several smaller pale green in color on the inside and top of their knowledge related to allegations.” These in-services will be complete by 11/16/10.

Any future allegations of abuse and its investigation with results will be reviewed and reported to the PI Committee monthly for 6 months and until investigation reports are found to be complete.

The Membership of the PI (QA) Committee is: Medical Dir, Admin, DON, ADON; MDS Coordinator, Staff Development Dir, Directors of: Soc Services; Act; Business Office; Dietary Services, Hsgk/Laundry, Maintenance, Med Records and PI (QA) Team Leader(s).

The Administrator is responsible for overall compliance.
Continued From page 2

of the right thigh. Further review of the investigation revealed "...when I asked resident how bruises got there, (resident) said 'boy...when I asked what the boy looked like...big or little... (resident) showed me with...hand, low to the floor...approximately 1-2 feet in height...when I asked color of hair (resident) pointed to my desk top which is light green...earlier in AM...I received documentation from night supervisor regarding (night supervisor's statement dated July 31, 2010) about resident's brother's conversation with (name nurse on night shift)...that resident told...brother that boy hit...brother asked (nurse) if there was a boy working that shift and (nurse) said 'oh you mean (name) (referring to CNA #1)'"

Review of the facility's "Abuse" policy under "Compliance Guidelines" #2 revealed "Injuries of an unknown source are reported and investigated in accordance with this policy and its supporting procedures."

Interview with the DON on October 5, 2010, at 3:30 p.m., in the Wound Care Nurse's office, revealed the resident liked to sit on the bed, legs folded under, yoga style; and slap thighs. Continued interview with the DON revealed CNA#1 was not interviewed because the CNA was not working the night of July 30, 2010, but did work 10:00 p.m. to 6:00 a.m., on July 25, 26, 27, and 29; 6:00 p.m. to 6:00 a.m. on July 28. Interview with the DON revealed the bruises were fresh so the incident had to have occurred on July 31, 2010. Further interview with the DON revealed CNA#1 was not assigned to the resident so the CNA was not considered as abusing the resident. Further interview with the DON revealed the resident frequently hit both thighs and that this was felt to be the cause of the bruising. Review
| F 226 | Continued From page 3 of nurses notes verified this was an on-going behavior of the resident. Continued interview with the DON revealed the facility failed to follow their abuse policy to fully investigate timely an injury of unknown origin by interviewing all staff that had worked on the same unit the resident resided on. Interview with two random CNAs on October 18, 2010, at 9:15 a.m., in the nursing station, revealed no voiced concerns related to CNA #1’s treatment of residents. Continued interview with the CNAs revealed residents were clean and dry when the CNAs came on duty after CNA #1 had cared for the residents on nights. Telephone interview with LPN #1 on October 19, 2010, at 8:45 a.m., revealed the LPN had no voiced concerns with the care CNA #1 provided and revealed the LPN felt “100% that...was not capable of abusing residents.” |
| F 279 | The Facility currently utilizes the results of the patient assessment to develop, review and revise the Comprehensive Plan of Care. The facility develops a Comprehensive Plan of Care for each resident that includes measurable objectives and timetables to meet a resident’s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan describes the services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being as required, any services that would otherwise be required but are not provided due to the residents exercise of rights, including the right to refuse treatment.

**STREET ADDRESS, CITY, STATE, ZIP CODE**
112 HEALTH CARE DR
CARTHAGE, TN 37030

**DATE SURVEY COMPLETED**
10/19/2010

**COMPLAINT #26527**
483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

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**COMPLETION DATE**
11/16/10
Continued from page 5
ADLs and able to walk all about the facility.

Interview with the DON on October 5, 2010, at 3:30 p.m., revealed the DON was unaware the care plan stated the resident needed extensive assistance and confirmed the resident was independent in all ADLs.

COMPLAINT #26527
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 Inter-Disciplinary Team, which 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, 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 and interview the facility failed to revise the care plan to include essential information to provide care for one

F 279

F 280

A Comprehensive Plan of Care is developed within 7 days after the completion of the Comprehensive Assessment prepared by the Inter-Disciplinary Team (IDT). The Comprehensive Plan of Care is periodically reviewed and revised by the IDT Team after each assessment.

The Resident found to be affected by this deficient practice was identified as resident #1. The care plan for residents #1 has been reviewed and updated by the IDT by 11/1/2010.

Residents who have the potential to be affected by this deficient practice are all residents.

The Inter-Disciplinary Team will audit current residents Comprehensive Plan of Care for accuracy 11/12/2010.

An audit of the Comprehensive Plan of Care for accuracy will be completed by the IDT on new admissions within 35 days of admission.

Results of these audits will be reported to the Center PI (QA) Committee by the DON monthly x 3 months. The Medical Records Department will audit the Comprehensive Plan of Care for completion by random selection (minimum 8 charts) and report to the Center PI committee monthly for 3 months and quarterly thereafter x6 months.
F 280  Continued From page 7

best (resident) can tolerate...however, if the collar did become uncomfortable or started to cause pressure sores, it could be discontinued with the understanding that (resident) could wind up with a catastrophic spinal cord injury..." Medical record review revealed the resident was readmitted to the facility on August 26, 2010.

Medical record review of the current care plan updated September 9, 2010, revealed a problem of "Risk for falls/injury as evidenced by h/o (history of) falls, nonambulatory, dependent for transfers, incontinent of B&B (bowel and bladder), receives psychotropic and pain medications...2/17/2009 Keep bed in lowest position for safe transfers...06/18/2009 Falling stars program...09/22/2009 use hoist lift & 2 staff for all transfers...08/13/2009 fall intervention: pressure alarm at all times...bolsters on bed...

Interview with the Director of Nursing (DON) on October 5, 2010, at 3:50 p.m., in the Wound Care Nurse's office, revealed prior to the accident, the resident would "whip (resident) legs over the side of the geri chair. The resident was kept out at the nursing station so (resident) could look around and staff could keep an eye on the resident. The resident's daughter had said if (resident) got too noisy in the dining room, just to take (resident) to room and let (resident) look out window...that usually calms for a while..." Further interview with the DON revealed on August 24, 2010, "the resident was particularly rambunctious (noisy and yelling out) in the dining room so the CNA took the resident to the resident's room to look out the window.

Medical record review of the care plan revealed no mention the resident would sit up in a geri
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**NAME OF PROVIDER OR SUPPLIER:**

SMITH COUNTY HEALTH CARE CENTER

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

112 HEALTH CARE DR
CARTHAGE, TN 37030

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<td>chair or the chair needed to be reclined to prevent falls. Further review of the care plan revealed the statement &quot;Pressure alarm at all times&quot; but does not state whether that is to be in bed or in the chair or both. Continued review of the care plan revealed no approach of placing the resident in the room to look out the window when the resident became too noisy in the dining room. Further review of the care plan revealed no documentation of the fact the resident has a cervical collar in place or the need for specific care to prevent skin breakdown under the collar. Continued review of the care plan revealed no documentation the resident would whip legs over the side of the geri-chair, increasing the fall risk. Continued interview with the Director of Nursing (DON) on October 5, 2010, at 3:50 p.m., in the Wound Care Nurse’s office, revealed the DON was unaware of the omissions on the care plan but confirmed the issues should have been addressed. COMPLAINT #26680. 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, review of a</td>
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F323 It is the practice of this facility to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents. Residents #1 and #5 fall risk assessments have been reviewed and updated by the MDS Coordinator and the Interdisciplinary Team (IDT) on 10/29/10. Care plan reflects appropriate interventions for assistive devices in order to prevent accidents.
Continued From page 9

facility investigation, observation, and interview, the facility failed to provide supervision and/or ensure safety devices were in place for two residents (#1 and #5) of eleven residents reviewed. The facility’s failure resulted in harm to resident #1.

The findings included:

Resident #1 was admitted to the facility on February 4, 2009, with diagnoses including Dementia, Coronary Artery Disease, Placement of Stents, and Chronic Pain. Medical record review of the Minimum Data Set (MDS) dated August 18, 2010, revealed the resident was severely impaired cognitively; required two people for transfer; required extensive assistance with Activities of Daily Living (ADLs); was fed; and was incontinent of bowel and bladder.

Medical record review of a nurse’s note dated August 24, 2010, revealed “Called to room by CNA (Certified Nursing Assistant). Resident on floor on left side, facing away from window. Laceration to center of forehead. Blood pressure 220/119. Pressure alarm sounding.” Continued medical record review revealed the resident was transferred to the hospital for evaluation and treatment.

Medical record review of a hospital discharge summary dated August 26, 2010, revealed the resident suffered a "C1 (first cervical vertebra) impaction fracture with mild displacement of left lateral mass." Continued medical record review of the hospital discharge summary revealed "...did not feel (resident) was a candidate for any further treatment in terms of...fracture...did feel it would be best to keep (resident) in a collar as..."
F 323 Continued From page 10
best (resident) can tolerate...however, if the collar did become uncomfortable or started to cause pressure sores, it could be discontinued with the understanding that (resident) could wind up with a catastrophic spinal cord injury..." Medical record review revealed the resident was readmitted to the facility on August 26, 2010.

Review of the facility investigation dated August 24, 2010, revealed an untimed interview with CNA #1 on August 24, 2010, "went into the room to get tray, resident's chair was reclined all the way back when I left room." Continued review revealed an untimed interview with the Activities Director dated August 26, 2010, which stated "Passed room I noted ... was facing window with chair reclined." Further review revealed an untimed interview with CNA #2 dated August 24, 2010, which stated, "Brought resident out of dining room and took to room. Picked up tray and chair was reclined all the way back." Continued review revealed an untimed interview with the Registered Nurse dated August 24, 2010, who stated "Resident was laying on floor beside air conditioner on left side. Head turned on left side. Area 6"x9" blood pooled around head, face. Right hand laying flat in it. Turned resident on back. Left upper sleeve was soaked with blood. Cut blouse off and had large area that skin was all gone. All bleeding areas cleaned and wrapped." Further review revealed an untimed interview with the Maintenance Director dated August 24, 2010, who stated "Chair was in proper working order."

Observation of the resident on October 4, 2010, at 1:10 p.m., revealed the resident lying in bed on a pressure-relieving mattress on the back with a soft cervical collar in place. Continued
NAME OF PROVIDER OR SUPPLIER: SMITH COUNTY HEALTH CARE CENTER

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Observation revealed the resident did not respond to verbal comments. Observation of the resident on October 5, 2010, at 11:30 a.m., revealed the resident in bed with the head of the bed raised and the sitter beginning to feed lunch. Further observation revealed the resident was eating a puree diet and was able to utter some comments about lunch.

Interview with the Director of Nursing (DON) on October 5, 2010, at 3:50 p.m., in the Wound Care Nurse's office, revealed prior to the accident, the resident would "whip (resident) legs over the side of the geri chair. The resident was kept out at the nursing station so (resident) could look around and staff could keep an eye on the resident. The (resident's) daughter had said if (resident) got too noisy in the dining room, just to take (resident) to room and let (resident) look out window...that usually calms for a while...." Further interview with the DON revealed on August 24, 2010, "the resident was particularly rambunctious (noisy, yelling out) in the dining room so the CNA took the resident to the resident's room to look out the window (not the nurse's station where the resident could be observed).

Further interview with the DON revealed the Maintenance Director walked past the resident's room and noted the resident to be on the floor. Interview with the DON and Administrator on October 6, 2010, at 5:00 p.m., in the Administrator's office, revealed the resident was able to throw legs over the side of the geri chair but was unable to stand. Continued interview confirmed the resident was left alone in the room and the resident was not supervised or observed by staff resulting in a fall from the gerichair requiring hospitalization for a cervical fracture.
Resident #5 was initially admitted to the facility on July 7, 2009, and readmitted on October 28, 2009, with diagnoses including Dementia, Non-Insulin Dependent Diabetes Mellitus, Hypertension, Osteoarthritis, Coronary Artery Bypass Graft, and Chronic Renal Failure. A medical record review of the MDS dated September 8, 2010, revealed the resident had short and long term memory deficits; required assistance with ADLs; was occasionally incontinent of bowel and frequently incontinent of bladder; was independent with eating.


Interview with the DON on October 5, 2010, at
F 323 Continued From page 13

2:30 p.m., in the Wound Care Nurse's office, revealed the resident "goes through spells without falls then starts again. The resident gets belligerent and says 'I can do this.'" Continued interview with the DON revealed the DON was unaware how long it had been since Physical Therapy worked with the resident. Further interview with the DON confirmed the resident turned off or removed alarms so the alarms could not alert staff of unassisted transfers by the resident resulting in frequent falls.

COMPLAINT #26680