

FOOT#2
 Accepted 6/3/15
 No. 0535

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44E232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/22/2015
NAME OF PROVIDER OR SUPPLIER BLED SOE COUNTY NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 225 SS=D	<p>A Recertification survey and complaint investigation #35943 were conducted from 4/20/15 through 4/22/15, at Bledsoe County Nursing Home. No deficiencies were cited in relation to complaint #35943 under 42 CFR PART 483, Requirements for Long Term Care Facilities. 483.13(c)(1)(II)-(III), (c)(2) - (4)</p> <p>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported</p>	F 225	<p><u>F 225</u></p> <p>1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>Outside consultant reviewed policy in depth and interfaced with Social Worker on 5-12-15. SW, DON, and Administrator met regarding facility policy and federal and state regulations regarding timely reporting of allegations of abuse. Administrative team will review and revise policy as needed by 5/31/15.</p> <p>Incident reported to state electronically on 6-2-15</p>	6/5/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Sharon Holliday RN Assist. Adm TITLE _____ (X6) DATE *6-2-15*

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44E232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2015
NAME OF PROVIDER OR SUPPLIER BLEDSON COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	<p>Continued From page 1</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the facility policy, review of an abuse investigation and interview, the facility failed to report 1 allegation of abuse to the State of 1 abuse investigation reviewed.</p> <p>The findings included:</p> <p>Review of the facility policy Abuse, Neglect, Misappropriation Protocol with a revised date of 12/2014, revealed "...The Administrator will provide a written report of the results of all abuse investigations and appropriate action taken to the state survey and certification agency...within five (5) working days of the reported incident..."</p> <p>Review of an allegation of abuse investigation dated 4/6/15, revealed no documentation the allegation had been reported to the State.</p> <p>Interview with the Social Worker/Abuse Coordinator on 04/21/2015, at 4:20 PM, in the Conference room, revealed the allegation of abuse had been reported to the Social Worker. Continued interview revealed the Social Worker had investigated the allegation and found it to be unsubstantiated. Continued interview revealed "if allegations of abuse are investigated and found to be unsubstantiated they are not reported to the</p>	F 225	<p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>All residents have the potential to be affected by this practice.</p> <p>3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <p>Mandatory inservices "Abuse Reporting" will be scheduled for all staff to be completed by 6/5/15 regarding appropriate reporting procedures. Social Worker and DON are responsible for this inservice.</p> <p>For the next 6 months, staff will monthly be questioned and reminded of appropriate reporting procedures for any resident abuse during staff Huddles. Social Worker and DON will be responsible for this information during Huddles.</p>		

Cont'd →

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44E232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/22/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER BLEDSON COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 225	<p>Continued From page 1</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the facility policy, review of an abuse investigation and interview, the facility failed to report 1 allegation of abuse to the State of 1 abuse investigation reviewed.</p> <p>The findings included:</p> <p>Review of the facility policy Abuse, Neglect, Misappropriation Protocol with a revised date of 12/2014, revealed "...The Administrator will provide a written report of the results of all abuse investigations and appropriate action taken to the state survey and certification agency...within five (5) working days of the reported incident..."</p> <p>Review of an allegation of abuse investigation dated 4/6/15, revealed no documentation the allegation had been reported to the State.</p> <p>Interview with the Social Worker/Abuse Coordinator on 04/21/2015, at 4:20 PM, in the Conference room, revealed the allegation of abuse had been reported to the Social Worker. Continued interview revealed the Social Worker had investigated the allegation and found it to be unsubstantiated. Continued interview revealed "if allegations of abuse are investigated and found to be unsubstantiated they are not reported to the</p>	F 225	<p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>Social Worker will report at quarterly QAPI meetings regarding any allegations of abuse that have been reported as well as outcomes of monthly Huddle meetings regarding abuse.</p> <p>Social Worker, DON, or Administrator will be responsible for reporting any future allegations of abuse and subsequent investigations of reported abuse to appropriate state agencies.</p>	
-------	---	-------	---	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44E232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/22/2015
NAME OF PROVIDER OR SUPPLIER BLED SOE COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 2 state. If substantiated they are reported immediately." Further interview confirmed the facility had failed to report an allegation of abuse to the State.	F 225		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan 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 must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25, but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review and interviews, the facility failed to develop a care plan that included post dialysis care, for 1 resident (#8) of 2 residents receiving dialysis of 18 residents reviewed. The findings included:	F 279	F 279 1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE? Resident #8: care plan was revised by the Care Plan/MDS Coordinator to include the location of the AV fistula as well as accessing for bruit/thrill during post dialysis assessments. 2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE? The charts/care plans of all dialysis patients were reviewed to ensure location of AV fistula/shunt as well as assessing for bruit/thrill. Only one other dialysis chart was found and new orders written for correct location of AV fistula/shunt and for assessment to include bruit/thrill/.	6/6/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44E232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/22/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER BLEDSON COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	<p>Continued From page 3</p> <p>Review of facility policy for Post Dialysis Care revealed "...Assessment of access site for bleeding Assessment of AV (arterial venous) fistula/graft strength of thrill (vibration of blood felt flowing through the access) and bruit..." (sound heard through use of a stethoscope of blood flowing through the access)</p> <p>Medical record review revealed Resident #8 was admitted to the facility on 3/3/2015, with diagnoses including: Status Post Pacemaker, End Stage Renal Disease on Hemodialysis, Atrial Fibrillation and Weakness.</p> <p>Medical Record review of the care plan dated 3/16/2015, revealed the location of the dialysis access and the need to assess the dialysis access site for bruit/thrill post dialysis, had not been included in the care plan.</p> <p>Interview with Minimum Data Set (MDS) Nurse on 4/21/15, at 4:30 PM, in the MDS office confirmed the location of the dialysis access site had not been included in the care plan.</p> <p>Interview with the Director of Nursing (DON) on 4/22/15, at 9:25 AM, in the DON's office, confirmed the facility had failed to care plan the dialysis access site and post dialysis care to assess the dialysis site for the bruit/thrill according to facility policy.</p>	F 279	<p>3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <p>Nurses were inserviced in huddle (between each shift) as well as 1 on 1 between April 22 and April 24, 2015 as well as staff inservice on 5/13/15 by the DON, with review of policy for assessment post dialysis.</p>	
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,</p>	F 309	<p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>All dialysis patients admitted will be reviewed to ensure documentation of location of fistula/shunt as well as correct assessment of bruit/thrill. This will be done by the DON and MDS coordinator. Results will be reported and monitored through QA meetings quarterly.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44E232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2015
NAME OF PROVIDER OR SUPPLIER BLEDSON COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 4</p> <p>mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical records, and interviews, the facility failed to assess the dialysis access site for bruit/thrill for 1 resident (#8) of 2 residents receiving dialysis out of 18 residents reviewed.</p> <p>The findings included:</p> <p>Review of facility policy for Post Dialysis Care revealed "...Assessment of access site for bleeding Assessment of AV (arterial venous) fistula/graft strength of thrill (vibration of blood felt flowing through the access) and bruit..." (sound heard through use of a stethoscope of blood flowing through the access)</p> <p>Medical record review revealed Resident #8 was admitted to facility on 3/3/2015, including the diagnoses Status Post Pacemaker, End Stage Renal Disease on Hemodialysis, Atrial Fibrillation, and Weakness.</p> <p>Medical record review of the nurse's notes for the month of April 2015, revealed 9 post dialysis site assessments documented by 4 Licensed Practical Nurses (LPN's). None of the nurse's notes included the location of the dialysis access site or assessment of the bruit/thrill.</p> <p>Telephone interview with LPN #2 on 4/22/15, at 9</p>	F 309	<p>F 309</p> <p>1.) WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>Resident #8: 1 on 1 Inservice with Charge Nurses was done between April 22 and April 24 to ensure each nurse knew how to assess for bruit/thrill by the DON. Also, order was written on April 23, 2015 to reflect location of fistula and included on Treatment Record.</p> <p>2.) HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>The charts/treatment records of all dialysis patients were reviewed to ensure location of AV fistula/shunt as well as assessing for bruit/thrill. Only one other dialysis chart, order was written to include correct location and also to include checking for bruit/thrill.</p>	6/6/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44E232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2015
NAME OF PROVIDER OR SUPPLIER BLEDSON COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 5 AM, confirmed she had not checked the bruit/thrill when she assessed the dialysis site on 4/8/15 and on 4/13/15. Telephone interview with LPN #1 on 4/22/15, at 9:05 AM, confirmed she had not checked the bruit/thrill when she assessed the dialysis site on 4/1/15, 4/6/15, 4/10/15, and 4/17/15. Interview with the Director of Nursing (DON) on 4/22/15, at 9:25 AM, in the DON's office confirmed the facility had failed to assess the bruit/thrill post dialysis according to facility policy.	F 309	<p>3.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <p>Nurses were inserviced in huddle (between each shift) as well as 1 on 1 between April 22 and April 24, 2015 as well as staff inservice on 5/13/15 by the DON, with review of policy for assessment post dialysis and verbal instructions to include location of fistula.</p> <p>4.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>All dialysis patients admitted will be reviewed to ensure documentation of location of fistula/shunt as well as correct assessment of bruit/thrill. This will be done by the DON and MDS coordinator. Each month the Treatment records will be monitored to ensure location of fistula is documented. Results will be reported and monitored through quarterly QA meetings.</p>		