

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

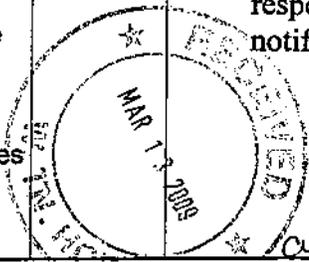
PRINTED: 03/02/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2009
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NAME OF PROVIDER OR SUPPLIER BELCOURT TERRACE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 BELCOURT AVENUE NASHVILLE, TN 37212
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F 159 SS=D	<p>483.10(c)(2)-(5) PROTECTION OF RESIDENT FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the</p>	F 159	<p>Preparation and/or execution of this plan of correction do not constitute admission or agreement by this provider 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/or state law. The plan of correction constitutes my credible allegation of compliance.</p> <p>F-159</p> <p>I. Resident #1, #3 and their responsible parties have been notified of the amount in their resident trust funds</p> <p>II. Resident accounts have been audited. Residents and responsible parties have been notified if applicable</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 3/2/09
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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 after 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 after 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.

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F 159	<p>Continued From page 1</p> <p>SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of financial statements, and interviews, it was determined the facility failed to notify medicaid recipients when their personal funds exceeded the \$2000.00 resource limit for 2 of 9 (Resident #3 and Random Resident (RR) #1) medicaid recipients reviewed with funds being managed by the facility.</p> <p>The findings included:</p> <p>1. Review of Resident #3's annual Minimum Data Set (MDS) dated 6/3/08 and the quarterly MDS date 12/3/08 identified Resident #3's payor source as being medicaid.</p> <p>Review of the resident trust fund quarterly financial statements on 2/19/09 at 3:00 PM revealed Resident #3 had a balance of \$5,231.72 for the quarter of 10/1/08 through (-) 12/31/08.</p> <p>During an interview in the Business Office Manager's (BOM) office on 2/19/09 at 3:00 PM, the BOM confirmed that Resident #3 had a current balance that exceeding the \$2000.00 limit for one person. The BOM confirmed that, prior to the survey, the facility had not contacted the family or Responsible Party (RP) to advise them of the situation, so the money could be spent to</p>	F 159	<p>III. The Business Office Manager has been re-educated on the resident trust fund requirements</p> <p>IV. The Administrator, Business Office Manager and/or Designee will complete random audits of resident trust funds monthly for 3 months, then quarterly for 2 quarters. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed</p> <p>V. Completion Date: March 19, 2009</p>	
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F 159	Continued From page 2 purchase items and services the resident needed. 2. Review of the quarterly statements for 10/1/08-12/31/08 revealed Random Resident #1 had a balance of \$3,266.94 in the trust fund account. During an interview in the BOM's office on 2/19/09 at 3:00 PM, the BOM confirmed the RP had not been informed that RR #1's trust fund balance exceeded the resource amount of \$2000.00 allowance.	F 159		
F 160 SS=D	483.10(c)(6) CONVEYANCE UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on review of resident trust fund statements and an interview, it was determined the facility failed to convey funds held in the resident trust fund, to the individual or probate jurisdiction administering the estate for 1 of 5 (Random Resident #2) discharged resident records reviewed. The findings included: Review of the resident trust fund statements revealed a balance of \$60.00 being held in the trust fund for Random Resident #2. During an interview in the Business Office	F 160	F-160 I. Resident #2's trust fund balance has been dispersed II. Resident discharges in past 30 days have been audited and funds dispersed if applicable III. The Business Office Manager has been re-educated on conveyance of resident trust funds upon death. IV. The Administrator, Business Office Manager and/or Designee will complete random audits of trust funds for discharged residents monthly for 3 months, then quarterly for 2 quarters. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed	

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F 160 Continued From page 3
Manager's (BOM) office on 2/19/09 at 3:00 PM, the BOM stated Random Resident #2 expired on 9/10/08. The BOM was asked if there was a reason the funds were not conveyed within 30 days of discharge. The BOM stated, "It [refunding of the \$60.00 fell through the cracks."

F 160

V. Completion Date: March 19, 2009

F 161
SS=C 483.10(c)(7) ASSURANCE OF FINANCIAL SECURITY

The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

F 161

F-161
I & II. The surety bond currently exceeds the balance of the resident trust fund

This REQUIREMENT is not met as evidenced by:
Based on review of the current surety bond, review of bank statements for the resident trust fund, and an interview, it was determined the resident trust fund balance exceeded the amount of the surety bond for 3 of 3 (11/08, 12/08 and 1/09) monthly statements reviewed.

III. The Business Office Manager has been re-educated on the surety bond requirements

The findings included:
1. Review of the facility's current surety bond was revealed to be in the amount of \$20,000.00.
2. Review of the monthly bank statements for the last quarter revealed the following:
a. The 11/30/08 average daily balance was \$23,806.00
b. The 12/31/08 average daily balance was \$24,639.63
c. The daily balance for 1/9/09 through 1/16/09 exceeded \$21,000.00 on 1/9/09, 1/12/09, 1/13/09, and 1/16/09.

IV. The Administrator, Business Office Manager and/or Designee will complete random audits of resident trust fund balances and surety bond monthly for 2 months, then quarterly for 2 quarters. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed

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<p>F 161</p> <p>F 248 SS=D</p>	<p>Continued From page 4</p> <p>During an interview in the Social Services office, 2/19/09 at 3:45 PM, the Business Officer Manager confirmed the monthly bank statement balances reflected on the above statements exceeded the surety bond amount.</p> <p>483.15(f)(1) ACTIVITIES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the activity calendar, observations, and interviews, it was determined the facility failed to provide an ongoing activity program designed to meet the individual needs for 1 of 10 (Resident #3) sampled residents.</p> <p>The findings included:</p> <p>Medical record review for Resident #3 (65 years of age) documented an admission date of 1/8/07 and current diagnoses of Vascular Dementia, Seizures, Aphasia, Dysphagia, and Gastrostomy Tube (GT). Review of the annual Minimum Data Set (MDS) dated 6/3/08 assessed Resident #3's cognitive patterns with both short and long term memory impairment. Resident #3 was assessed as nonambulatory and totally dependent upon staff for all Activities of Daily Living (ADL). Under the MDS section of activity pursuit documentation showed time was spent awake in the morning and afternoons with involvement in activities 1/3 to 2/3 of the time, not involved in treatments or ADL</p>	<p>F 161</p> <p>F 248</p>	<p>F-248</p> <p>I. Resident #3 has been re-assessed for activity needs. Progress notes and care plan reflects current activity needs</p> <p>II. Residents have been re-assessed for activity needs. Progress notes and care plans reflect current activity schedule</p> <p>III. The Activity Director, Social Worker and nursing staff have been re-educated on providing assistance with activity needs for residents and documentation to reflect current plans</p> <p>IV. The Activity Director, Social Worker and/or Designee will complete random audits of resident activity involvement as per assessment and plan of care weekly for 4 weeks, monthly for 3 months then quarterly for 2 quarterly. Results of the audits will be reviewed at the Quality Assurance meeting for revisions as needed.</p> <p>V. Completion Date: March 19, 2009</p>	
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F 248	<p>Continued From page 5</p> <p>care. Review of the current MDS dated 2/3/09 revealed no changes in those assessments. Review of the form dated 4/11/07 and titled resident activity interview, documented that Resident #3 enjoyed bowling, baseball, being read to, all types of music, bingo with assistance, television (TV), radio and small dogs. Review of Resident #3's current care plan revealed no plan of care for activities.</p> <p>Review of a list of activities, provided by the Activities Director (AD), revealed activities provided from 1/5/09 through 2/16/09 included 3 times a week activities involving a talking library tape, reading or music. All but 4 of those were in room activities.</p> <p>Review of the February 2009 Activity Calendar revealed the scheduled activities for 2/18/09 included the name of the person who would entertain at 10:30 AM and bingo at 3:00 PM.</p> <p>Observations in Resident #3's room on 2/17/09 at 10:50 AM and 12:40 PM, revealed Resident #3 alone in his room in a reclined gerichair with the TV on a children's learning program.</p> <p>Observations in Resident #3's room on 2/18/09 at 7:55 AM, revealed Resident #3 in the gerichair while the TV was on a children's learning channel with animated characters reciting letters from the alphabet. Resident #3 laughed, but made no other vocalizations.</p> <p>Observations in the dining room on 2/18/09 at 11:05 AM, revealed a pianist and a singer performing for several residents. Resident #3 was not in attendance.</p>	F 248		
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F 248	<p>Continued From page 6</p> <p>Observations in Resident #3's room on 2/18/09 between 2:30 PM and 2:45 PM, revealed Resident #3 alone in the room, in a low bed and awake, looking at this speaker but no other response. The bed was too low to allow the resident a view from the window. The TV was off and there was no music in the room. There was no radio, tape or compact disc (CD) player in the room.</p> <p>During an interview in Resident #3's room on 2/18/09 between 2:45 and 3:00 PM, the Activities Director (AD) confirmed the TV was off and when the TV was turned on, it was tuned to a children's learning program. The AD confirmed Resident #3 did enjoy music of all kinds and was not at the musical on 2/18/09. The AD confirmed there was no source to provide music in the room, such as a radio or CD player. The AD confirmed that Resident #3 did not have any of those items of his own, but stated, "I have a radio, I bring in sometimes." The AD confirmed that Resident #3 enjoyed the activity of bingo, which was scheduled to be played at 3:00 PM, yet Resident #3 was in his room in bed at 3:00 PM.</p> <p>During an interview in the Social Services office, on 2/18/09 at 5:00 PM, with the MDS Coordinator stated, "He [Resident #3] does not have an activity care plan...[the AD] filled out the MDS section of activities."</p> <p>During an interview in the Social Services office, 2/18/09 at 5:05 PM, the AD stated that Resident #3 is involved in activities approximately 3 times per week and each activity documented lasted about 30 to 45 minutes. The AD confirmed Resident #3 spent about 2 to 3 hours each week in activities which did not amount to 1/3 to 2/3 of</p>	F 248		

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F 248	Continued From page 7 his waking hours. The AD confirmed there was no care plan for providing Resident #3 with activities he enjoyed.	F 248		
F 250 SS=D	<p>483.15(g)(1) SOCIAL SERVICES</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to ensure medically-related social services were provided to maintain the highest mental, and psychosocial well being for 1 of 10 (Resident #5) sampled residents.</p> <p>The findings included:</p> <p>Medical record review for Resident #5 documented an admission date of 7/5/07 and re-admission date of 10/1/08 with diagnoses of Diabetes Mellitus, Poly Neuropathy, Dysphasia, Hypertension, Heart Disease, Chronic Renal Disease, Coronary Artery Disease, Suicidal Thoughts, and Major Depressive Disorder. Review of the current Minimum Data Set (MDS) assessment dated 11/28/08 documented no mood or behavior issues under the mood and behavior sections.</p> <p>Review of Resident #5's nurses notes documented the following: a. 9/5/08 at 8:53 AM - "Alert with confusion noted change in mental status and mood appears depressed refuses to get up in the A.M. for</p>	F 250	<p>F-250</p> <p>I. The Social Worker has assessed Resident #5 for psychosocial needs. Progress notes and care plans reflect current psychosocial needs</p> <p>II. Residents with depression have been re-assessed. Progress notes and care plans reflect current psychosocial needs</p> <p>III. The Social Worker has been re-educated on providing support/referrals and documentation requirements</p> <p>IV. The Social Worker, MDS Nurse and/or Designee will complete random audits of progress notes, assessments and care plans for depression weekly for 4 weeks, monthly for 3 months then quarterly for 2 quarters. Results of the audit will be reviewed at the Quality Assurance meeting for revisions as needed</p> <p>V. Completion Date: March 19, 2009</p>	

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F 250	<p>Continued From page 8</p> <p>breakfast had to be prompt to take shower res [resident] tearful on occasion change from normal happy mood."</p> <p>b. 9/6/08 at 11:07 PM - "[Resident] has been fairly good this afternoon except his depression is becoming more apparent..."</p> <p>c. 9/8/08 at 10:53 PM - "...daughter here and stated that he seemed more depressed..."</p> <p>d. 9/10/08 at 10:51 PM - "Resident refused diner, medications and accuchecks. Informed Resident of the risk he is taking, he nodding understanding. Informed by ADON [Assistant Director of Nursing] that Resident has been about death and showing/verbalizing depressive signs/symptoms."</p> <p>e. 9/22/08 at 8:21 AM - "This nurse passed resident while on his way to dining room and noted resident to crying when asked what was wrong resident stated "I just wish I was dead" after talking with him for a few minutes found that he had lost his billfold over the weekend and had been crying off and on since Friday per residents daughter assisted resident to dining room and set up breakfast tray and assured resident that I would look in laundry for his wallet spoke with daughter on the phone after this incident and she stated he is just getting worse every day with crying and being upset will cont [continue] to monitor." 9/22/08 at 12:41 PM - "Upon entering residents room to soak foot noted resident to be lying in bed with bed raised in the highest position when asked why he had his bed so high he stated "because when I fall on my head I want to make sure I die." lowered the bed to lowest position and phoned the daughter she stated "I wish you could talk to [name of Physician] and see about sending him to a psych [psychiatric] hospital and see whats going on with him before he does something crazy." called [name of Physician] and left message awaiting a return call." 9/22/08 at</p>	F 250		

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F 250	<p>Continued From page 9</p> <p>2:52 PM - "Received a return call from [name of Physician] and received an order to send out for psych eval [evaluation]. phoned daughter and notified her of the new order and she requested that the transfer be set up for the am that way she could come and visit and explain what is going on. will let social services know of new order."</p> <p>f. 12/18/089 at 7:55 AM - "[Resident #5's name] is depressed this morning, while I was checking his BG [blood glucose] he states that, you will be glad when I will be gone, I asked gone where? pt. [patient] states to cemetery, and then he started laughing..."</p> <p>g. 1/14/09 at 2:53 PM - "Resident is showing signs of depression this shift. Refusing to go to dining room for meals. Not participate in activities. Talking about wanting to die. Daughter is aware. Here this shift. Will cont to monitor."</p> <p>Review of Resident #5's Social Service Director (SSD) progress notes documented the following:</p> <p>a. 9/23/08 at 12:10 PM - "Resident is depressed, crying and making statements that he would be better dead. I spoke with him and his daughter, [named daughter], and they are agreeable to a psych stay. His information has been faxed to [Psychiatric Hospital] for review."</p> <p>b. 10/11/08 at 12:11 PM - "...He was sent to [name of Psychiatric Hospital] for depression. He was crying and expressing that he wanted to die. He has improved with the hospital stay. He has had no behaviors over this assessment period."</p> <p>c. 10/12/08, 10/30/08, 12/1/08, 12/29/08 and 1/21/09 - Resident #5 "has had no mood or behavior problems during this assessment period."</p> <p>During an interview in the SSD's office on 2/18/09 at 8:28 AM to 8:42 AM, the SSD stated she would</p>	F 250		
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NAME OF PROVIDER OR SUPPLIER BELCOURT TERRACE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 BELCOURT AVENUE NASHVILLE, TN 37212
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F 250	Continued From page 10 not be the person responsible for referring anyone to the Psychiatrist. "The DON [Director of Nursing] would refer [residents] to the Psychiatrist." The SSD stated she was aware of the resident talking about wanting to die. The SSD stated she was informed of the issues in the morning meetings and by reading the nursing notes. The surveyor reviewed the SS progress notes with the SSD. The SSD confirmed the SS notes had no documentation prior to the discharge date of 9/23/08 to the Psychiatric Hospital. The SSD stated she was responsible for the mood and behavior sections of the MDS. The SSD confirmed that the depressive symptoms displayed by the resident had not been documented. The surveyor reviewed the Psychiatric progress notes with the SSD. The SSD confirmed the Psychiatric progress notes contained no documentation of suicidal thoughts/behaviors or any interventions.	F 250		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS 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 interdisciplinary team, that 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, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	F 280		

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F 280	<p>Continued From page 11 and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interviews, it was determined the facility failed to revise care plans for the use of hand cones with the mitts, activities, suicidal thoughts with preventative approaches, new interventions following falls, weight gain or the discontinued use of an electric wheelchair for 4 of 10 (Residents #3, 5, 6 and 8) sampled residents.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Medical record review for Resident #3 documented an admission date of 1/8/07 and current diagnoses of Vascular Dementia, Seizures, Aphasia, Dysphagia, and Gastrostomy Tube (GT). Review of the annual Minimum Data Set (MDS) dated 6/3/08 and 2/3/09 assessed Resident #3's cognitive patterns with both short and long term memory impairment. Resident #3 was assessed as nonambulatory and totally dependent upon staff for all Activities of Daily Living (ADL). <p>Review of a form titled Rehabilitation Screening Assessment documented an entry dated 1/7/08 and signed by Certified Occupational Therapy Assistant (COTA #1) which documented, "Nursing referral: Res. [Resident] screened. Unable to use progressive hand splint 2 (secondary to) mittens that need to be donned. POC. [Plan of Care] Nursing to use hand cone c</p>	F 280	<p>F-280</p> <ol style="list-style-type: none"> I. Resident #3, #5, #6, and #8's care plans have been reviewed and revised as needed to meet current care needs II. Resident care plans have been reviewed and revised if needed to meet current care needs III. The Interdisciplinary Care Plan Team and licensed nurses have been re-educated on the care plan process IV. The Director of Nursing, MDS Nurse and/or Designee will complete random audits weekly for 4 weeks, monthly for 3 months then quarterly for 2 quarters. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed V. Completion Date: March 19, 2009 	
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F 280	<p>Continued From page 12</p> <p>[with] mitten over." Another entry dated 3/9/08 and signed by COTA #1 documented, "No [changes] noted. Continue to use cone in hands [with] mittens. OT 0 [not] warranted at this time." The last entry on that form was dated 1/16/09 and documented, "[No] OT services warranted at this time. No [change] in functional status." There was no documentation on those screening assessments that the cones should be discontinued.</p> <p>During an interview in the Social Service Director's (SSD) office on 2/19/09 at 12:50 PM, COTA #1 reviewed the Rehabilitation Screening Forms and confirmed that there had been no recommendations to discontinue the use of hand cones. The hand cones had been recommended for use with the mittens to reduce the risk of contractures. COTA #1 further explained that Resident #3 could not use hand splints because he required the mittens to prevent the behavior of chewing on his thumb and could use the cone with the mittens. COTA #1 stated, after getting Resident #3's hands relaxed enough to open for cleaning that morning, rolled washcloths were used in the hands to "simulate the cone...same effect and is working fine."</p> <p>Review of Resident #3's current care plan identified a problem and start date of 8/4/08 "At risk for complications r/t [related to] hand mitts to remind resident not to chew hands." The care plan had not been revised to reflect the COTA's recommended intervention of hand cones with the mitts to reduce the risk of contractures.</p> <p>Further medical record review revealed a form titled Resident Activity Interview dated 4/11/07 revealed the activities Resident #3 enjoyed, per</p>	F 280		

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F 280	<p>Continued From page 13</p> <p>information from the family, included bowling, baseball, being read to, all types of music, bingo with assistance, Television (TV), radio and small dogs.</p> <p>During an interview in the Social Service's (SS) office on 2/18/09 at 5:00 PM, the MDS Coordinator stated, "He [Resident #3] does not have an activity care plan...[the AD] filled out the MDS section of activities."</p> <p>During an interview in the SS office on 2/18/09 at 5:05 PM, the Activity Director (AD) confirmed there was no care plan for providing Resident #3 with activities he enjoyed.</p> <p>2. Medical record review for Resident #5 documented an admission date of 7/5/07 and a re-admission date of 10/1/08 with diagnoses of Diabetes Mellitus, Polyneuropathy, Dysphagia, Hypertension, Heart Disease, Chronic Renal Disease, Coronary Artery Disease, Suicidal Ideations, Depressive Disorder. Review of nurses notes documented the following:</p> <p>a. 8/22/08 at 7:25 PM - "Resident found sitting on floor in bathroom in room, resident stated "I was trying to go to the bathroom and lost my footing," resident had feces all over him and floor, after washing resident and assisting a full body assessment was done with no injury noted, resident c/o [complained of] pain to knees although neither were red or had injury noted..."</p> <p>b. 12/22/08 - "Responding to call light resident noted attempting to transfer self from bed into w/c [wheelchair] without assist resulting in resident slipping to floor on buttocks. Resident did not hit head. ROM [range of motion] to all extremities without difficulty. No apparent injury noted..."</p> <p>Review of the current care plan for Resident #5</p>	F 280		

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F 280	<p>Continued From page 14</p> <p>documented a problem "At risk for falls related to cognition, musculoskeletal impairment, sensory impairments and medications." There was no documented updates on the care plan with new interventions to prevent further falls.</p> <p>During an interview in the SS's office on 2/18/09 at 9:00 AM, the Care Plan Coordinator (CPC) confirmed that the care plan had not been updated with new interventions to prevent further fall occurrences.</p> <p>Further medical record review revealed hospital records dated 9/23/08 that documented Resident #5 "was admitted to this facility for depression and suicidal ideations." Discharge diagnoses included Severe Depressive Disorder with Suicidal Thoughts. Review of Resident #5's current care plan dated 12/10/07 documented a problem of "Dysfunctional grieving: depression related to psychiatric conditions." There was no evidence the care plan was updated to address the problem of suicidal thoughts with preventative approaches initiated.</p> <p>During an interview in the SS office on 2/18/09 at 10:15 AM, the Care Plan Coordinator confirmed there was no care plan for a problem of suicidal thoughts.</p> <p>3. Medical record review for Resident #6 documented an admission date of 5/18/06 with diagnoses of Mental Retardation, Convulsions, Cerebral Palsy, and Anxiety. The Registered Dietician (RD) progress note dated 1/7/09 at 11:17 AM documented the resident had a significant weight gain of 10 pounds in one month. The RD progress note also documented, "Weight gain may be r/t [related to] increased</p>	F 280		
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F 280	<p>Continued From page 15</p> <p>snacking...PCP [patient care plan] reviewed /updated..." Review of the current care plan dated 8/15/07 with a goal target date of 4/13/09 documented an approach to "encourage to eat" and no new approaches were documented to reflect the significant weight gain.</p> <p>During an interview in the Director of Nurses' (DON) office, on 2/19/09 at 10:40 AM, the MDS Coordinator confirmed the care plan was updated at the bottom of the care plan where it documented "Evaluation notes: 01/07/09, RD [name] PCP reviewed/updated. Sign [significant] wt [weight] gain." The MDS coordinator and DON confirmed the approach to "encourage to eat" on the current care plan should be revised.</p> <p>4. Medical record review for Resident #8 documented an admission date of 12/14/07 with diagnoses of Acute Respiratory Distress, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Hypertension, and Schizophrenia. The Physician orders dated 2/1/09 to 2/28/09 documented "Reclined geri chair when up for comfort and positioning, and splint application on right arm on 4 hours and off 2 hours." Review of the Certified Nursing Technician (CNT) care plan documented the means of "locomotion" as a "wheelchair - ele. [electric]."</p> <p>During an interview at the nursing station on 2/19/09 at 2:50 PM, CNT #2 stated, "We have these tech [technician] information sheets that tell us what to do for each patient." CNT #2 obtained a white notebook from a shelf and turned to Resident #8's "information sheet", and stated "We don't put him in a electric wheelchair no more, we use a reclining gerichair now because he can't sit</p>	F 280		
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F 280	Continued From page 16 up in the wheelchair no more." CNT #2 denied ever seeing or using a splint on the right arm/hand as ordered. CNT #2 stated she did not know who was responsible for updating the CNT "information sheets" in order to ensure care was rendered to each resident as per orders.	F 280		
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations and interviews, it was determined the facility failed to provide hand washing for hand contractures 2 of 9 (Residents #3 and 8) sampled residents observed. The findings included: 1. Medical record review revealed for Resident #3 documented an admission date of 1/8/07 and current diagnoses of Vascular Dementia, Seizures, Aphasia, Dysphagia, and Gastrostomy Tube (GT). Review of the annual Minimum Data Set (MDS) dated 6/3/08 and 2/3/09 assessed Resident #3 as nonambulatory and totally dependent upon staff for all ADL's (activities of daily living). Observations in Resident #3's room on 2/19/09 at 8:32 AM, revealed Resident #3 dressed and reclined in a gerichair with padded Posey mittens on both hands, sucking and chewing on the right	F 312	F-312 I. Resident #3 and #8's hands are being cleaned daily and as needed II. Residents have been assessed and assistance with hygiene is being provided daily and as needed III. Nursing staff has been re-educated on providing assistance with personal hygiene/bathing per residents' plan of care IV. The Director of Nursing, Assistant Director of Nursing and/or Designee will complete random audits or resident hygiene 3 times a week for 4 weeks, weekly for 1 month then monthly for 3 months. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed V. Completion Date: March 19, 2009	

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F 312	<p>Continued From page 17</p> <p>mitten. A foul body odor was noted in the room.</p> <p>During an interview in the back hallway on 2/19/09 at 8:35 AM, Certified Nursing Technician (CNT #2) stated Resident #3 was bathed, dressed and gotten out of bed by staff on the night shift and was not scheduled for a bath or shower this date.</p> <p>During an interview in Resident #3's room on 2/19/09 at 8:35 AM, the Director of Nursing (DON) confirmed the mittens were wet and emitted a foul odor.</p> <p>Observations in Resident #3's room on 2/19/09 at 8:35 AM, the DON removed Resident #3's mittens. Resident #3's hands were clinched so tightly into fists that it was difficult to open them. The DON was able to get one finger opened to reveal the palms were white with dried skin visible and some of the odor was coming from the palm.</p> <p>Observations in Resident #3's room on 2/19/09 at 8:50 AM, revealed Certified Occupational Therapy Assistant (COTA #1) and CNT #3 worked with Resident #3 to open the hands so they could be washed. COTA #1 confirmed the hands had a foul odor.</p> <p>2. Medical record review for Resident #8 documented an admission date of 5/4/04 with diagnoses of Acute Respiratory Distress, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Hypertension, and Schizophrenia.</p> <p>Observations and interviews in Resident #8's room on 2/19/09 at 2:40 PM, revealed Resident #8 lying in bed with the head of the bed raised</p>	F 312		

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F 312	<p>Continued From page 18</p> <p>approximately 45 degrees. Resident #8 had his right hand and arm under the sheet. Resident #8 was asked about the splints that were supposed to be applied to the right hand and arm. Resident #8 removed his right arm from the sheet. At that time there was a strong pungent odor noted. Resident #8's right middle, ring, and fourth fingers were in a flexed contracted position toward the palm, and the odor was emitting from the resident's hand.</p> <p>During an interview in the hallway outside Resident #8's room on 2/19/09 at 2:45 PM, the Care Plan Coordinator (CPC) stated she had checked on Resident #8 and the odor had been coming from his contracted hand. The CPC stated she cleaned Resident #8's hand and put a roll in between the contracture to keep it dry and prevent the odor.</p> <p>Observations in Resident #8's room on 2/19/09 at 4:40 PM, Resident #8 was seated in a reclining gerichair. COTA #1 was finishing up applying the splint ordered for the right hand contracture. There was a very strong, foul, odor in the room. COTA #1 confirmed the odor was from Resident #8's right hand. COTA #1 stated, "The CNT cleaned it [Resident #8's hand] real good before I put the splint on and it [odor] should be better soon."</p>	F 312		
F 315 SS=D	<p>483.25(d) URINARY INCONTINENCE</p> <p>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</p>	F 315		

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F 315	<p>Continued From page 19</p> <p>treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observations and interviews, it was determined the facility failed to promote urinary continence for 2 of 9 (Residents #5 and 7) sampled residents with urinary incontinence.</p> <p>The findings included:</p> <p>1. Medical record review for Resident #5 documented an admission date of 7/5/07 and a re-admission date of 10/1/08 with diagnoses of Diabetes Mellitus, Polyneuropathy, Dysphagia, Hypertension, Heart Disease, Chronic Renal Disease, Coronary Artery Disease, Suicidal Thoughts, and Depressive Disorder. Review of the current bowel and bladder assessment dated 10/3/08 documented a total score of 7. A score of 0 to 8 documented, "good candidate for individualized training." The current quarterly Minimum Data Set (MDS) assessment dated 11/28/08 documented long and short term memory was intact and the resident was independent with cognitive decision making. Resident #5 was coded as being mostly incontinent of bladder. The facility was unable to provide documentation of a timed or trail voiding pattern for Resident #5.</p> <p>During an interview in the Social Service (SS) office on 2/18/09 at 9:10 AM, the Director of Nursing (DON) was asked about the status of Resident #5's bladder incontinence. The DON</p>	F 315	<p>F-315</p> <p>I. Resident #5 and #7 have been re-assessed for possible bladder retraining and trial programs implemented as per assessments</p> <p>II. Residents are being re-assessed per the MDS/care plan schedule and trial programs implements where appropriate</p> <p>III. Licensed nurses have been re-educated on the bladder retraining assessments/program</p> <p>IV. The Director of Nursing, MDS Nurse and/or Designee will complete random audits of bladder assessments/program implementation weekly for 4 weeks, monthly for 3 months then quarterly for 2 quarters. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.</p> <p>V. Completion Date: March 19, 2009</p>	

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NAME OF PROVIDER OR SUPPLIER BELCOURT TERRACE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 BELCOURT AVENUE NASHVILLE, TN 37212
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F 315	<p>Continued From page 20</p> <p>stated, "He's [Resident #5] just lazy. He don't want to get up and go the bathroom, he would rather wear a brief and go in it."</p> <p>During an interview in Resident #5's room on 2/18/09 at 10:50 AM, Resident #5 stated, "Sometimes I don't make it to the bathroom on time and I dribble on myself and I don't want my clothes wet. I go to the bathroom for number 2 [defecate] and the staff helps me get the brief back on."</p> <p>2. Medical record review for Resident #7 documented an admission date of 11/6/08 and diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Hypertension, and Chronic Renal Insufficiency. Resident #7's care plan dated 11/6/08 documented "Check res [resident] for incontinent episodes and change prn [as needed] providing incontinent care after each episode." The admission MDS dated 11/13/08 assessed Resident #7 as frequently incontinent of urine with multiple episodes per day. The bowel and bladder assessment dated 12/1/08 documented Resident #7 as a candidate for toileting schedule/ time voiding.</p> <p>Observations and interview in Resident #7's room on 2/19/09 at 2:20 PM, revealed an elevated commode seat over the toilet in her bathroom. Resident #7 confirmed she knows when she needs to go to the bathroom but the commode toilet seat is too small for her.</p> <p>During an interview in the SS office on 2/19/09 at 3:15 PM, the MDS Coordinator confirmed the type incontinence was never determined because when Resident #7 was admitted she did not feel the urge to void. The MDS Coordinator also</p>	F 315		
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F 315	Continued From page 21 confirmed Resident #7 was never on a bladder training program and there is no documentation to show the resident was taken to the bathroom on a timed schedule.	F 315		
F 318 SS=E	<p>483.25(e)(2) RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observations and interviews, it was determined the facility failed to ensure that range of motion was not decreased for 2 of 4 (Residents #3 and 8) sampled residents identified with actual or potential for decreased range of motion.</p> <p>The findings included:</p> <p>1. Medical record review for Resident #3 documented and admission date of 1/8/07 with current diagnoses of Vascular Dementia, Seizures, Aphasia, Dysphagia, and Gastrostomy Tube (GT). The annual Minimum Data Set (MDS) dated 6/3/08 assessed Resident #3 as nonambulatory and totally dependent upon staff for all activities of daily living (ADL).</p> <p>Review of a form titled Rehabilitation Screening Assessment dated 1/7/08 and signed by Certified Occupational Therapy Assistant (COTA #1) documented, "Nursing referral: Res. [Resident]</p>	F 318		

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F 318	<p>Continued From page 22</p> <p>screened. Unable to use progressive hand splint 2 (secondary to) mittens that need to be donned. POC. [Plan of Care] Nursing to use hand cone c [with] mitten over." Another entry date of 3/9/08 and signed by COTA #1 documented, "No [changes] noted. Continue to use cone in hands [with] mittens. OT 0 [not] warranted at this time." The last entry on that form was dated 1/16/09 and documented, "[No] OT services warranted at this time. No [change] in functional status." There was no documentation on those screening assessments that the cones should discontinued.</p> <p>Observations in Resident #3's room on 2/18/09 at 7:55 AM, revealed Resident #3 in a gerichair with both hands enclosed in padded Posey mittens. Resident #3's hands were observed through the mesh fabric to be folded into fists within the mittens.</p> <p>Observations in Resident #3's room on 2/19/09 at 8:32 AM, revealed Resident #3 dressed and reclined in a gerichair with padded Posey mittens on both hands, sucking and chewing on the right mitten.</p> <p>Observations in Resident #3's room on 2/19/09 at 8:35 AM, the Director of Nursing (DON) removed Resident #3's mittens. Resident #3's hands were clinched so tightly into fists that it was difficult to open them.</p> <p>Observations in Resident #3's room on 2/19/09 at 8:50 AM, the certified Occupational Therapy Assistant (COTA #1) and Certified Nursing Technician (CNT #3) worked with Resident #3 to open the hands so they could be washed. COTA #1 confirmed Resident #3's hands were clinched tightly into fists and she was assisting CNT #3 to</p>	F 318	<p>F-318</p> <p>I. Resident #3 and #8 have been re-assessed for therapy recommendations. Recommendations are being implemented and are documented on the plan of care</p> <p>II. Residents with assistive devices have been assessed and devices are being used as per recommendations and plans of care</p> <p>III. Nursing staff has been re-educated on assistive devices and following recommendations, plan of care and documentation requirements</p> <p>IV. The Director of Nursing, Assistant Director of Nursing and/or Designee will complete random audits of residents with assistive devices 3 times a week for a month, weekly for 1 month then monthly for 3 months. Results of audits will be reviewed at the Quality Assurance meeting for revisions as needed</p> <p>V. Completion Date: March 19, 2009</p>	

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F 318	<p>Continued From page 23</p> <p>get Resident #3 to relax the hands so they could be washed.</p> <p>During an interview in the Social Services (SS) office on 2/19/09 at 12:50 PM, COTA #1 reviewed the Rehabilitation Screening Forms and confirmed that there had been no recommendations to discontinue the use of hand cones, which were recommended for use with the mittens to reduce the risk of contractures. COTA #1 explained that Resident #3 could not use hand splints because he required the mittens to prevent the behavior of chewing on his thumb and could use the cone with the mittens. COTA #1 stated that after getting Resident #3's hands relaxed enough to open for cleaning that morning, rolled washcloths were used in the hands to "simulate the cone...same effect and is working fine."</p> <p>Review of the current care plan revealed an identified problem and start date of 8/4/08 "At risk for complications r/t [related to] hand mitts to remind resident not to chew hands." The care plan was not revised to reflect the COTA recommended intervention of hand cones with the mitts to reduce the risk of contractures.</p> <p>2. Medical record review for Resident #8 documented an admission date of 5/4/04 with diagnoses of Acute Respiratory Distress, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Hypertension, and Schizophrenia. Review of physician re-cap orders dated 2/1/09 to 2/28/09 documented "Splint application on R [right] arm on 4 hours and off 2 hours."</p> <p>Observations and an interview in Resident #8's room on 2/17/09 at 10:30 AM, revealed Resident</p>	F 318			

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F 318	<p>Continued From page 24</p> <p>#8's right middle, ring and pinkie fingers were contracted in a flexed position toward the palm of the right hand. Resident #8 stated, "I have had a stroke and my hand has been like that since. It was several years ago...maybe 3 years, I don't know." Resident #8 was observed not to have a splint applied to the right arm/hand and there was no splint in the room.</p> <p>During an interview in Resident #8's room on 2/19/09 at 2:40 PM, Resident #8 stated, "They [nursing home staff] used to put a splint on it everyday but they haven't done it in about a year now."</p> <p>During an interview at the nurses' station on 2/19/09 at 2:50 PM, CNT #2 stated she had taken care of Resident #8 "on and off for the 8 or so months I have been here." CNT #2 stated, "I have never put any splints on him [Resident #8]. I didn't know he was supposed to have them." CNT #2 obtained a white notebook from a shelf that had a "CNT Information sheet" for Resident #8 inside. CNT #2 stated if the technicians were supposed to apply splints it would be written under the "Restorative" section of the information sheet. Review of that information sheet revealed no documentation that a splint was or had been applied.</p> <p>During an interview in the hallway just outside of the SS office door, on 2/19/09 at 3:10 PM, CNT #3 stated he had been assigned to take care of Resident #8 for "over a year now." CNT #3 stated he had never seen splints put on Resident #8 and had never applied any splints for the resident. CNT #3 stated, "I wasn't aware that he was ordered splints."</p>	F 318		

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F 318	<p>Continued From page 25</p> <p>During an interview at the nurses' station on 2/19/09 at 3:20 PM, the MDS Coordinator stated the nurses were putting the splints on and signing off on a treatment sheet that was on the Medication Administration Record (MAR). Review of the treatment sheet submitted by the Care Plan Coordinator, revealed documentation of "splint on right hand/arm" with nursing initialing on all 3 shifts; "7-3 shift, 3-11 shift, 11-7 shift."</p> <p>During an interview at the nurses' station on 2/19/09 at 3:30 PM, Licensed Practical Nurse (LPN #1) stated, "I don't know anything about any splints he is suppose to have." LPN #1 was shown the physician order that documented "Splint application on R [right] arm on 4 hours and off 2 hours." LPN #1 was questioned about what her initials on the treatment record indicated. LPN #1 stated, "It [splint] is on there as Q [every] shift so I was signing that it [splint] was off on my shift." LPN #1 stated, "Therapy puts the splint on and I was signing it [MAR] to say they [therapy] had put it [splint] on day shift and on my shift it [splint] was off." LPN #1 denied ever seeing a splint on Resident #8's right hand/arm.</p> <p>During an interview in the Therapy room, on 2/19/09 at 4:15 PM, the COTA #1 stated Resident #8 was fitted for the splint by the Occupational Therapist (OT) and discharged to nursing to apply the splint on 10/4/06.</p>	F 318		
F 319 SS=D	<p>483.25(f)(1) MENTAL AND PSYCHOSOCIAL FUNCTIONING</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.</p>	F 319		

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Continued From page 26

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This REQUIREMENT is not met as evidenced by:
Based on medical record review and an interview, it was determined the facility failed to provide immediate treatment and services for suicidal thoughts and statements for 1 of 10 (Resident #5) sampled residents.

The findings included:

Medical record review for Resident #5 documented an admission date of 7/5/07 and a re-admission date of 10/1/08 with diagnoses of Diabetes Mellitus, Poly neuropathy, Dysphasia, Hypertension, Heart Disease, Chronic Renal Disease, Coronary Artery Disease, Suicidal Thoughts, and Major Depressive Disorder. Review of Resident #5's nurses notes documented the following:
a. 9/5/08 at 8:53 AM - "Alert with confusion noted change in mental status and mood appears depressed refuses to get up in the A.M. for breakfast had to be prompt to take shower res [resident] tearful on occasion change from normal happy mood."
b. 9/6/08 at 11:07 PM - "[Resident #8] has been fairly good this afternoon except his depression is becoming more apparent..."
c. 9/8/08 at 10:53 PM - "...daughter here and stated that he seemed more depressed..."
d. 9/10/08 at 10:51 PM - "Resident refused dinner, medications and accuchecks. Informed resident of the risk he is taking, he nodding understanding. Informed by ADON [Assistant Director of Nursing] that resident has been about death and showing/verbalizing depressive signs/symptoms."

F-319

- I. The Social Worker has assessed Resident #5 and completed progress notes and care plan review with interventions to assist resident to meet psychosocial needs
- II. Residents with depression have been re-assessed. Progress notes and care plans reflect current psychosocial needs.
- III. The Social Worker has been re-educated on providing support/referrals and documentation requirements
- IV. The Social Worker, MDS Nurse and/or Designee will complete random audits of progress notes assessments and care plans for psychosocial needs, weekly for 4 weeks, monthly for 3 months then quarterly for 2 quarters
- V. Completion Date: March 19, 2009

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F 319	<p>Continued From page 27</p> <p>e. 9/22/08 at 8:21 AM - "This nurse passed resident while on his way to dining room and noted resident to crying when asked what was wrong resident stated "I just wish I was dead" after talking with him for a few minutes found that he had lost his billfold over the weekend and had been crying off and on since friday per residents daughter assisted resident to dining room and set up breakfast tray and assured resident that I would look in laundry for his wallet spoke with daughter on the phone after this incident and she stated he is just getting worse every day with crying and being upset will cont [continue] to monitor." 9/22/08 at 12:41 PM - "Upon entering residents room to soak foot noted resident to be lying in bed with bed raised in the highest position when asked why he had his bed so high he stated "because when I fall on my head I want to make sure I die" lowered the bed to lowest position and phoned the daughter she stated "I wish you could talk to [name of Physician] and see about sending him to a psych [psychiatric] hospital and see whats going on with him before he does something crazy" called [name of Physician] and left message awaiting a return call."</p> <p>Review of the "Psychological Progress Note" dated 8/18/08 documented a diagnoses of "Major Depression" however, there was no documentation of suicidal ideation or suicidal behavior. There was no documentation of interventions for prevention of potential suicidal behavior. The follow up psych visit was dated 10/13/08, after Resident #5 was hospitalized for suicidal thoughts and behavior. The Psychological progress notes contained no documentation of suicidal thoughts or behavior and there were documented interventions put in place.</p>	F 319		

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During an interview in the Social Services office, on 2/18/09 at 8:28 AM to 8:42 AM, the Social Service Director (SSD) stated she would not be the person responsible for referring anyone to the Psychiatrist. The SSD stated, "The DON [Director of Nursing] would refer to the Psychiatrist." The SSD stated she was aware of Resident #5 talking about wanting to die, and having suicidal thoughts/behavior. The SSD stated she was informed of the issues with the resident in the morning meetings and by reading the nursing notes. The SSD stated the Psychiatrist should be making monthly visits with the resident. The SSD confirmed the Psychological Progress Notes dated 8/18/08 to 1/9/09 had no documentation of suicidal thoughts or behavior and contained no interventions.

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371 SS=F 483.35(i) SANITARY CONDITIONS
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

This REQUIREMENT is not met as evidenced by:
Based on policy review, observation and interview, it was determined the facility failed to ensure that food was stored, dated and prepared under sanitary conditions as evidenced by dirty stove burners, no test strips for testing the three compartment sink, no expiration date for foods stored in the refrigerator, water soaked pads on

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F 371	<p>Continued From page 29</p> <p>the floor, items stored on floor, outdated food products, a dirty floor with dead roaches in a food storage area, standing dirty water in the janitor's closet, and failure to maintain sanitary conditions while testing tray line temperatures.</p> <p>The findings included:</p> <p>1. Review of the facility's "Three Compartment Sink Policy" revealed "...Test concentration with test strips and record on log. Concentration should be 200 ppm [parts per million]. Keep immersed in sanitizing basin for 10 seconds.]</p> <p>Observations during the initial tour of the kitchen on 2/17/08 beginning at 10:10 AM revealed the following:</p> <p>a. Six burners on the stove top had thick black, crusty residue and oily substance in each drip pan and black streaks running down the right side of the stove.</p> <p>b. The coffee maker had light color crumbs around the top opening and streaks of residue on the sides and bottom.</p> <p>c. A large pot on the top of the stove was filled with oil and thick, crusty, black residue which covered the entire bottom and 8 inches up the side of the pot. The lid covering the pot had brown colored residue, crumbs and an oily substance around the edges and handle.</p> <p>d. A two gallon cooking pot on an overhead rack had black corrosion four inches up the side and covering the bottom.</p> <p>e. The three compartment sink had pots and utensils soaking in the wash water. The wash water tested at 98 degrees and rinse water was 107 degrees. No sanitizer strip was available to test the sanitizing compartment. The Dietary Manager (DM) and Dietary Aide looked for strips</p>	F 371	<p>F-371</p> <p>I. 1. The stove and coffee maker have been cleaned. The cooking pots have been cleaned and/or replaced where needed. Sanitizing test strips are available and being used in the 3-compartment sink. Food items are being dated after opening and in non-leaking containers. Mops are being used for floor spills.</p> <p>2. Food items are being stored on shelves or pallets as needed. Expired food items have been discarded. The room beside the storage area has been cleaned.</p> <p>3. Staff are washing their hands and testing of temperatures are being completed in a sanitary manner.</p> <p>4. The drain in the janitor's closet is functioning.</p> <p>II. The kitchen and food storage areas have been checked and are clean. Food items are dated after opening and expiration dates are current. Cleaning schedules have been reviewed, revised where needed and implemented. The emergency food supply has a dated inventory list available.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2009
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NAME OF PROVIDER OR SUPPLIER BELCOURT TERRACE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 BELCOURT AVENUE NASHVILLE, TN 37212
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F 371	<p>Continued From page 30</p> <p>but were unable to produce them. The Dietary Aid was observed washing the dishes at 10:50 AM with no test strips available to confirm if the sanitizing solution equaled the ppm.</p> <p>f. The refrigerator located near the stove contained a metal vat of vanilla pudding with no date; a large plastic container of unidentified red, tomato like substance with no date; three open plastic bags of hot dogs, sausage patties, and a piece of ham with no date.</p> <p>g. Two water soaked pads were located on the floor near the freezer.</p> <p>h. A tray of prune juice in the refrigerator/cooler located across from the coffee pot had dried juice in the tray and two of the 10 containers of prune juice were leaking.</p> <p>During an interview in the kitchen on 2/17/09 beginning at 10:10 AM, the DM stated, "I don't know where those strips are; they usually stay right here." When questioned regarding the cleaning of the coffee pot filter, the DM stated, "We pour hot water through it. We clean it when it's dirty." The DM was unable to identify a removable filter or provide a cleaning schedule. When questioned regarding the leaking freezer the DM stated, "They've been working on the freezer a couple of weeks."</p> <p>2. Observations in the Rooms B2 and B4 food storage areas, on 2/18/09 beginning at 9:20 AM, revealed the following:</p> <p>a. A cardboard box containing powdered sugar and a box of new china plates were stored on the concrete floor.</p> <p>b. Six boxes of "Quaker Barley" stored past the expiration date of 3/26/04.</p> <p>c. Four cartons of 40 ounce (oz) hashbrown potatoes with no date.</p>	F 371	<p>III. The Dietitian/QA Nurse has provided re-education for the dietary staff on kitchen sanitation, 3 compartment sink testing, dating food items, monitoring expiration dates, checking food temperatures, food storage and maintenance requests. The Director of Nursing has re-educated the dietary staff on hand washing procedures with return demonstration.</p> <p>IV. The Dietitian, Administrator, Dietary Manager and/or Designee will complete random dietary sanitation audits 3 times a week for 4 weeks, weekly for 1 month, monthly for 3 months. Results of the audits will be reviewed at the Quality Assurance meeting for revisions as needed.</p> <p>V. Completion Date: March 19, 2009</p>	
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F 371	<p>Continued From page 31</p> <p>d. Twenty four cans of Lactose Free Nestle Carnation Instant Breakfast with an expiration date of July 2008.</p> <p>e. Two one-gallon cans of Herb Vinaigrette with an expiration date of June 2007.</p> <p>f. Two number 10 cans of green peas with no expiration date and rust spots on the cans.</p> <p>g. Two cans of Three Bean Salad with an expiration date of September 2007.</p> <p>h. One 4 pound (lb) can of light Chicken Tuna with no date.</p> <p>i. Five 16 ounce (oz) cans of Cranberry Sauce with an expiration date of 2/4/07.</p> <p>j. One 7 lb 10 oz plastic tub of Peach Filling with no date and a thick layer of dirt covering the top of the tub.</p> <p>k. Five 37.5 oz plastic bags of Hashbrown Potatoes and two 5 lb bags of Potato Slices with no date.</p> <p>l. Thirty-five dusty, plastic jugs of water with either no date or a date of "Best by 03/2007."</p> <p>m. A shower room, opening off the B4 storage area had no door. Ten large dead cockroaches were in the floor. Black, thick corrosion and loose particles were along the base of the door opening. Old pieces of hose, chemical cans, discarded buckets, metal pipes, and pieces of debris were scattered about the floor. A cardboard box with eleven corroded cans of "Foaming Grill Cleaner" was in the floor.</p> <p>During an interview in Rooms B2 and B4 food storage areas, on 2/18/09 at 9:40 AM, the DM was asked about the required three day emergency food supply. The DM stated, "I calculate by guess work. I still don't know the amount and how to figure it. When the date goes out we throw it away and replace it; we don't rotate." The DM was asked about the expired</p>	F 371		
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F 371	<p>Continued From page 32</p> <p>dates on the food items in the storage area. The DM stated, "I'll get rid of it all; start over and that will be the safest thing to do."</p> <p>3. Observations during the tray line temperature check in the kitchen on 2/18/09 at 12:11 PM revealed the following:</p> <p>a. The DM entered the kitchen to check the tray line food temperatures. Without washing his hands and without donning gloves, he stuck the thermometer in the Salisbury Steak without first cleaning the probe.</p> <p>b. When checking the Noodles the sanitary wipe cover, and not the sanitary wipe itself, was used to wipe the probe and the thermometer was inserted up past the bottom of the hub which had not been cleaned.</p> <p>c. The entire thermometer was dropped into the corn and became completely submerged. The DM then utilized the scoop in the corn to remove the thermometer and returned the scoop to the corn for serving.</p> <p>During an interview in the DM's Office, on 2/19/09 at 9:20 PM, the concerns observed during the tray line temperature checks were discussed with the DM. The DM stated, "I probably did; I was just nervous."</p> <p>During an interview in the kitchen on 2/19/09 at 3:35 PM, the Dietician was asked for a policy on thermometer cleansing and tray line temperature checks. The Dietician stated, "We don't have one."</p> <p>4. Observations in the Janitor's closet for the kitchen, on 2/18/09 at 2:30 PM, revealed dirty, gray water approximately 4 inches deep standing in a 2 foot by 2 foot stationary vat.</p>	F 371			

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F 371	Continued From page 33	F 371		
F 465 SS=D	<p>483.70(h) OTHER ENVIRONMENTAL CONDITIONS</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and an interview, it was determined the facility failed to maintain a clean, sanitary environment in 1 of 4 central bath/shower rooms.</p> <p>The findings included:</p> <p>Observations of the central bath located between resident room 4A and 5A on 2/17/09 at 9:55 AM, revealed the tiled shower walls to the left, right and back of the shower were covered with a dried, white residue. The tiled floor was dirty with brownish stains by the drain of both shower areas, and the grout of the tile had a buildup of black residue.</p> <p>During an interview in the central bath located between resident room 4A and 5A on 2/17/09 at 10:05 AM, housekeeper #1 confirmed the presence of the findings documented above.</p>	F 465	<p>F-465</p> <p>I. The Central Bath by 4A and 5A has been cleaned.</p> <p>II. Shower rooms have been checked and are clean. Cleaning schedules have been reviewed and revised if needed.</p> <p>III. Housekeeping staff has been re-educated on cleaning procedures.</p> <p>IV. The Administrator, Housekeeping Supervisor and/or Designee will complete random audits of the shower rooms weekly for 4 weeks, monthly for 3 months then quarterly for 2 quarters</p>	3/19/2009