

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

POC # 2 *acceptable*

PRINTED: 11/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/21/2015
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NAME OF PROVIDER OR SUPPLIER ALEXIAN VILLAGE OF TENNESSEE	STREET ADDRESS, CITY, STATE, ZIP CODE 671 ALEXIAN WAY SIGNAL MOUNTAIN, TN 37377
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F 000	INITIAL COMMENTS	F 000	Alexian Village Health and Rehabilitation Center offers this Plan of Correction as its allegation of compliance with the participation requirements for long term care facilities and as evidence of its ongoing efforts to provide quality care to residents.	
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update</p>	F 157	<p>Disclaimer Statement</p> <p>Alexian Village Health and Rehabilitation Center does not admit that any deficiencies existed, before, during or after the survey. Alexian Village Health and Rehabilitation Center reserves all rights to contest the survey findings through the IDR, formal appeal proceeding or any administrative or legal proceedings. This POC is not meant to establish any standard of care or contractual obligation and Alexian Village Health and Rehabilitation Center reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this POC should be deemed applicable to peer review, quality assurance or self-critical examination privileges which Alexian Village Health and Rehabilitation Center does not waive.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Adm	(X6) DATE 11-18-15
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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 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.

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F 157	<p>Continued From page 1</p> <p>the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, observation, and interview, the facility failed to notify the physician of behavioral changes for one resident (#57) of 3 residents reviewed for behavior disturbances of 29 sampled residents.</p> <p>The findings included:</p> <p>Review of the facility's policy Behavioral Emergencies dated 9/5/14 revealed, "...should a resident become hostile or unmanageable in any way that would jeopardize his or her safety of others, the Nurse must immediately...Notify the resident's attending physician for instructions...Notify Primary Care Provider (PCP)..."</p> <p>Medical record review revealed Resident #57 was admitted to the facility on 7/24/15 and readmitted on 9/17/15 with diagnoses including Depressive Disorder, Dementia without Behavioral Disturbances, Dementia with Lewy Bodies, Anxiety, and Dysphagia.</p> <p>Observation on 10/21/15 at 9:04 AM, in the resident's room, revealed Resident #57 was dressed sitting in his wheelchair and picking up a pillow off the floor.</p> <p>Observation on 10/21/15 at 1:36 PM, in the resident's room, revealed resident #57 was sitting in the wheelchair talking to his wife.</p>	F 157	<p>QAPI Committee Members –</p> <p>President & CEO Administrator Sponsor Liaison Medical Director Pharmacy Consultant Interim DON Director of Quality Wound Care/Infection Control Case Management Medical Records Dietician MDS Director MDS Nurse Dinning Services Activities Environmental Services Director of Plant Operations Facility Services Executive Director AL & MC Executive Director AVR</p> <p>All monitoring will be reviewed monthly at QAPI meeting. All staff not working on in-service dates were called to come in for a mandatory in-service on 11/9 – 11/11. All staff not able to attend this in-service were taken off the schedule and in-serviced on a 1-1 basis. All in-service education was</p>	
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F 157	Continued From page 2 Medical record review of the Nursing Interdisciplinary Progress Note dated 10/2/15 revealed, "...Late entry: 10-01-2015...While changing resident he became very agitated and was grabbing cna [Certified Nursing Assistant] and twisting her arm..." Medical record review of the Care Plan dated 10/1/15, revealed "...has impaired behavior related to becoming agitated when his needs are not immediately met by staff...I will demonstrate optimal ADL [Activities of Daily Living] functioning and safety..." Medical record review of the Nursing Interdisciplinary Notes dated 10/5/15 revealed, "...resident was sitting on the side of the bed again this time he became very agitated and...was twisting my arm and fingers..." Medical record review of Physician orders dated 10/20/15 revealed no documentation of any orders after the behavioral changes on 10/1/15 and 10/5/15. Interview with Licensed Practical Nurse (LPN) #6 on 10/21/15 at 9:19 AM, in 5th floor nursing station, confirmed the physician was not notified after the behaviors on 10/1/15 and 10/5/15. Interview with the Interim Director of Nursing on 10/21/15 at 11:01 AM, in the 8th floor hallway, revealed, "The physician was not notified of his behaviors after 10/1/15 or 10/5/15."	F 157	added to new employee orientation packet (Attachment #1). All in-serviced information will be added to annual education/skills check off for all staff (Attachment #2). F157 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 1. Resident # 57's family and physician were notified of resident's change of behavior. Resident went to neurologist and received medication adjustment for behaviors. 2. DON reviewed behavior monitoring sheets, 24-hour reports, nursing documentation for resident behavior changes and found that no other residents had behavior changes for which the family and physician were not notified. 3. System process used to monitor change of behaviors was reviewed and found deficient practice occurred due to change in DON/ADON and Nurse Managers. System was revised to ensure that RN Managers are assigned review of 24-hour report (Attachment #3B) daily, to identify residents	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		

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F 226	<p>Continued From page 3</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, interview, and facility investigation review, the facility failed to ensure all alleged misappropriation of property was reported to the appropriate entities for one resident (#15) of 29 residents reviewed.</p> <p>The findings included:</p> <p>Review of the facility policy Missing Items/ Concerns revealed, "...The Administrator or designee will notify the appropriate individual(s), per state and federal regulations, on the status of investigation. If misappropriation is thought of, immediate reporting to the State with full detailed report to follow within (5) business days..."</p> <p>Medical record review revealed Resident #15 was admitted to the facility on 8/24/14 with diagnoses including Thyroid Disorder, Arthritis, and Hyperlipidemia.</p> <p>Medical record review of the resident's Brief Interview for Mental Status (BIMS) revealed a score of 15 indicating the resident was cognitively intact.</p> <p>Interview with the resident on 10/19/15 at 2:55 PM, in the resident's room, revealed the resident's wedding rings were missing on</p>	F 226	<p>with any change of behaviors and make timely notification to family and physician. The 24-hour report, including information about behavior changes, will be brought to morning meetings, Monday through Friday. Policy and procedure was reviewed and nursing staff was educated (Attachment #3A) by ADON or designee.</p> <p>4. DON or designee will monitor (Attachment #3C) and report compliance of notification for residents with behaviors monthly, then audit at the direction of the QAPI Committee.</p> <p>F226 483.13 DEVELOP/IMPLEMENT ABUSE/NEGELECT, ETC POLICIES</p> <ol style="list-style-type: none"> 1. Policy on misappropriations was reviewed to ensure compliance with State and Federal notification requirements. 2. Director of Case Management/Social Services reviewed existing grievances for reportable incidences. No other reportable incidents were identified. 3. Director of Case Management/Social Services 	11/18/2015
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F 226	Continued From page 4 November 30, 2014. Continued interview revealed the resident contacted police and the facility reviewed security tapes, but the rings were not found.	F 226	did not have current policy specific to notification of misappropriation. Updated copy was given to Director of Case Management/Social services and Administrator. Director of Case Management/Social Services were educated on policy/procedure related to misappropriation reporting.	
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, review of facility documentation, interview, and observation, the facility failed to follow the care plan for transfers for two residents (#153 and #104) of 6 residents reviewed for falls of 29 residents sampled, resulting in Harm to resident #153. The findings included: Review of the facility Fall Management policy, revised 9/20/13, revealed "...Prevention...2. Those residents identified, as being at risk for falls will have individualized interventions added to their plan of care to decrease the risk of injury	F 282	Director of Case Management/Social Services educated staff (Attachment #4 A) on policy and procedure related to misappropriation reporting. Nurse Manager will review 24-hour report (Attachment # 4B) daily for reports of misappropriation and ensure that the missing item form is completed and given to Director of Case Management for review and follow-up. The 24-hour report and grievances be brought to morning meeting Monday-Friday. 4. Administrator or designee will monitor grievances (Attachment #4C) for potential misappropriations and ensure appropriate notification of State. Results will be reported in monthly QAPI meeting.	11/18/2015

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F 282	Continued From page 5 related to a fall... Medical record review revealed Resident #153 was admitted to the facility on 6/10/15 with diagnoses including Aspiratation Event, Aspiration Pneumonitis, Chronic Atrial Fibrillation, Dementia, Alzheimer's Disease, and Difficulty Walking. Medical record review of the resident's Minimum Data Set [MDS] dated 6/17/15 revealed the resident had cognitive impairment, memory problems, and required extensive assistance with transfers and ambulation. Medical record review of a nurse's note dated 6/27/15 revealed, "...called to resident's room at 1:20 AM by CNA [certified nursing assistant]. Resident found lying on her R [right] side on floor next to bed...unable to answer what happened or if she hit head...call made to Dr [doctor]...to update on resident condition. Order received to send to...hospital...for evaluation and treatment..." Review of the facility documentation of the fall dated 6/27/15 revealed interventions were in place at the time of the fall and included a low bed and nonskid socks. Medical record review revealed Resident #153 was readmitted back to the facility on 7/4/15 with diagnoses including Aftercare for Healing Traumatic Left Hip Fracture, Dementia, Atrial Fibrillation, and Muscle Weakness. Medical record review of the resident's plan of care dated 7/4/15 revealed "...need 2 person staff assistance with transfers...support with transfer with use of Hoyer lift [type of total dependence non weight bearing lift]..."	F 282	F282 483.20(K)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 1. Resident #153 was discharged. Resident #104 care plan reviewed with staff. Resident #104 was not harmed during transfer. CNA #1 terminated on 9/1/15. CNA #2 counseled and educate by ADON on following care plan for transfers. 2. Identified that changes in transfer status were not being communicated well from therapy staff to nursing staff to update plan of care and care profile. Therapy completed an audit of residents on 11/11, for appropriate transfer status. Any residents identified as such had care plan updated to appropriate transfer status by MDS nurse. 3. DON/ADON or designee educated staff (Attachment #5A) on how to locate transfer status information; this was added to 24-hour report (Attachment #5B) until transfer status moved to care profile. Interdisciplinary communication form will be completed by therapy and given to nursing staff; copy will		

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F 282	<p>Continued From page 6</p> <p>Medical record review of the Physical Therapy Evaluation and Plan of Treatment with a start date of 7/5/15 revealed, "...Transfers= [equals] Total Dependence w/o [without] attempts to initiate unable to perform sit to stand despite max [maximum] assist of 2...patient will require use of total dependence lift for OOB [out of bed transfer]..."</p> <p>Medical record review of a nurse's note dated 7/6/15 revealed "...@ [at] 1130 [11:30 AM] CNA and this nurse was transferring resident to restroom using the sit-to-stand lift [type of weight bearing lift]...Encouraging resident to bear weight on her right leg and toe touch with the left. Resident was cooperative and then suddenly said no and let go of the lift crossing her hands losing her balance in the lift. CNA and [charge nurse] assisted resident by lowering her to the floor...Assisted resident back to wheelchair x3 [with 3] staff members and then assisted resident to bed with assist from PT [Physical Therapy] department..."</p> <p>Medical record review of a nurse's note dated 7/7/15 at 1:11 AM revealed, "...Assessment of surgical site shows severe redness and warmth to 2 staples on left hip...Middle site has 2 inch surrounding area that is hard and red. Will alert day shift nurse of need to call surgeon in AM [morning]..."</p> <p>Medical record review of a nurse's note dated 7/7/15 at 10:13 AM, revealed, "...On assessment of surgical site distal from hip is red, hard, swollen, 2 inches by 2 inches...Md [Medical Doctor] called and informed. With new orders to apply warm compresses to area for 20</p>	F 282	<p>be given to MDS to verify status was updated in care plan. Transfer status will be updated on the 24-hour report nightly by nurses according to care plan and communication forms.</p> <p>4. DON or designee will observe 6 resident transfers per week for 4 weeks (Attachment #5C) to ensure they are completed per care plan. Then, DON or designee will observe 6 resident transfers per month for 11 months to ensure they are completed per care plan. This information will be reported at monthly QAPI meeting.</p>	11/18/2015

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F 282	<p>Continued From page 7 minutes...will continue to monitor..."</p> <p>Medical record review of a Physicians telephone order dated 7/8/15 revealed, "...x-ray to left hip and femur...pain..."</p> <p>Medical record review of a mobile image of the left hip dated 7/8/15 revealed, "...Findings: screw threads projecting beyond the superior margin of the femoral neck and appearing to impinge upon the lateral aspect of the acetabulum...Impressions: Recurrent fracture of the femoral neck versus malposition dynamic screw of the femoral neck...notified Dr...wants to see resident on...7/10/15..."</p> <p>Medical record review of a nurse's note dated 7/10/15 at 10:34 AM revealed, "...Left for Dr. [doctor] appointment at 1015 [10:15 AM]..."</p> <p>Medical record review of a Hospital Consultation Report dated 7/10/15 revealed "...recently fell...status post placement of an IM [intramedullary nail] nail to...left femur and was admitted to the hospital today for revision to a total hip arthroplasty on that side..."</p> <p>Medical record review of the Hospital Discharge summary dated 7/12/15 revealed discharge diagnoses included "...1. Status post fall. with a recurrent hip fracture. History of recent hip fracture. status post surgery. Second fall with a new hip fracture..."</p> <p>Interview and medical record review of the plan of care with the MDS coordinator on 10/21/15 at 1:20 PM, in the MDS office, confirmed the resident was to have a Hoyer lift for transfer. Continued interview revealed the MDS</p>	F 282		
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F 282	<p>Continued From page 8</p> <p>coordinator coordinates with physical therapy when developing the plan of care.</p> <p>Interview and review of the physical therapy evaluation and plan of treatment with the Physical Therapist on 10/21/15 at 1:27 PM, in the therapy room, confirmed the resident required a total dependence lift for transfers.</p> <p>Telephone interview with Licensed Practical Nurse (LPN) #3 on 10/21/15 at 1:12 PM, revealed the LPN did not look at the resident's plan of care prior to transferring the resident. Continued interview revealed the LPN used a sit-to stand lift instead of the Hoyer lift identified for use with the resident by therapy and nursing staff.</p> <p>Interview with the Medical Director on 10/21/15 at 12:48 PM, in the conference room, confirmed the resident's fall could have caused the re-injury to the resident's hip.</p> <p>Interview with the Interim Director of Nursing (DON) on 10/21/15 at 2:10 PM, in the DON office, confirmed the facility's failure to follow the resident's care plan and use the appropriate lift for transferring the resident, resulted in harm to the resident.</p> <p>Medical record review revealed Resident #104 was admitted to the facility on 8/12/15 with diagnoses including Pneumonia, Hemiplegia Affecting Dominant Side, Aphasia, History of Fall, Atrial Fibrillation, Chronic Kidney Disease Stage 3, Major Depressive Disorder, and Dysphagia.</p> <p>Medical record review of an admission nurse's note dated 8/12/15 revealed, "...resident requires</p>	F 282		
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F 282	<p>Continued From page 9</p> <p>max [maximum] assist with all ADLs [activities of daily living]..."</p> <p>Medical record review of the Admission MDS dated 8/19/15 revealed the resident scored an 8 on the Brief Interview for Mental Status (BIMS) indicating the resident was moderately cognitively impaired. Continued review revealed the resident required extensive assistance of 2 persons for bed mobility, transfer, dressing, and personal hygiene. Further review revealed the resident was only able to stabilize with the assistance of staff, and had limitation in range of motion in upper and lower extremities.</p> <p>Review of facility documentation dated 8/30/15 revealed Resident #104 had reported to the facility the resident had requested assistance with toileting on the evening of 8/29/15. Continued review revealed the resident stated CNA #1 had responded to the resident's request for assistance with getting to the toilet. Further review revealed the CNA had transferred the resident from the bed to a wheelchair, from the wheelchair to the toilet, and then back to the resident's bed. Further review revealed the resident was not injured during the transfer.</p> <p>Review of a witness statement signed and dated on 9/1/15 by CNA #1 revealed the CNA had transferred the resident without the assistance of another staff member.</p> <p>Medical record review of the resident's nursing care plan, last updated on 10/2/15, revealed "...needs assistance with daily ADL care; she is new admission to facility...I need 2 staff support with transfer...I need max assistance with mobility. I need 2 staff support with mobility...I</p>	F 282		
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NAME OF PROVIDER OR SUPPLIER ALEXIAN VILLAGE OF TENNESSEE			STREET ADDRESS, CITY, STATE, ZIP CODE 671 ALEXIAN WAY SIGNAL MOUNTAIN, TN 37377		
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F 282	Continued From page 11 the resident's ADL/Daily Care List care plan or by asking the nurses. Continued interview revealed Resident #104 was documented as requiring the use of 2 staff members for transfers. Continued interview confirmed CNA #1 had transferred the resident without the assistance of another staff person. Continued interview confirmed CNA #2 transferred the resident without assistance of another staff person on 10/20/15 at 4:20 PM. Interview with the Interim DON on 10/21/15, at 1:41 PM, in the Conference Room, revealed CNAs were required to read and acknowledge they have read the resident's ADL/Daily Care List which instructs CNAs on the level of assistance needed for transfers. Continued interview confirmed Resident #104 was documented on both the nursing and CNA care plan as requiring the use of 2 staff members for transfers. Continued interview confirmed the resident had required the assistance of 2 people for transfers on both 8/30/15 and on 10/20/15. Further interview confirmed both CNA #1 and CNA #2 had failed to follow the care plan during transfers.	F 282			
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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 treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	F315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 1. Resident #57 and resident #8 had new 3 day voiding trials completed and individualized toileting program put in place. DON/ADON educated nursing staff on process of bladder assessments and completion of individualized toileting program 11/9-11/11; DON educated MDS on evaluating a change in bladder function at time of scheduled MDS.		

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F 315	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, and interview, the facility failed to evaluate the need for an individualized bladder retraining program for two residents (#57 and #8) of three residents reviewed for urinary incontinence of 29 residents reviewed.</p> <p>The findings included:</p> <p>Review of the facility policy Restorative Nursing revised 2/28/14, revealed "...Residents who are not continent may be assessed by the nurse and/or therapist for a nursing restorative bladder-retraining program...Perform an interdisciplinary evaluation to assess cause of new incontinence..."</p> <p>Medical record review revealed Resident #57 was admitted to the facility on 7/24/15 and readmitted on 9/17/15 with diagnoses including Depressive Disorder, Dementia without Behavioral Disturbances, Dementia with Lewy Bodies, Anxiety, and Dysphagia.</p> <p>Medical record review of the Admission Assessment Minimum Data Set (MDS) dated 8/3/15 revealed a trial toileting program had not been attempted and the resident was frequently incontinent.</p> <p>Medical record review of the Significant Change MDS dated 9/2/15 revealed a trial toileting program had not been attempted and the resident was always incontinent.</p> <p>Medical record review of the Care Plan dated</p>	F 315	<ol style="list-style-type: none"> ADON completed a review of all resident bladder assessments for any decline in bladder function on 11/12. MDS nurse put an individualized toileting program in place for residents identified with toileting changes. Identified that we did not have a process in place to monitor changes in bladder function at the time of the scheduled assessments. Identified that direct care staff did not know who to notify when they noticed a change in bladder function of a resident. DON educated MDS on how to evaluate the change in bladder function and initiate new voiding diary if indicated. ADON and designee educated (Attachment #6A) all nurses/CNAs on completion of voiding diaries, notification process and individualized toileting programs. ADON will monitor new residents (Attachment #6B) through bladder assessments and implement individualized toileting program as indicated. All residents in MDS look-back 		

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F 315	<p>Continued From page 13</p> <p>10/9/15 revealed, "...(P)[Problem] has episodes of urinary and bowel incontinence...(A) [Approach] Provide adult incontinent products and monitor for incontinence..."</p> <p>Medical record review of the bladder evaluation and monthly toileting flowsheets and interview with Licensed Practical Nurse (LPN) #6 on 10/21/15 at 9:30 AM, in the 5th floor nursing station, revealed, "When he first came here his wife said he was not always incontinent at home but later she said he was incontinent. He uses his call light sometimes. He does not have a toileting diary for a 3 day bladder pattern documented during his admission time, I don't know what these numbers represent on the flowsheet, I do not have a key to explain the documentation." Further interview confirmed the monthly toileting flowsheet did not indicate if the resident was wet or dry when checked by the Certified Nursing Assistant (CNA).</p> <p>Interview with the Interim Director of Nursing (DON) on 10/21/15 at 1:10 PM in the DON's office, confirmed, "His bowel and bladder pattern was not assessed. He is not on a bowel and bladder program. He is being toileted. He was not reevaluated after his change in bladder continence."</p> <p>Medical record review revealed Resident #8 was admitted to the facility on 5/22/15 with diagnoses including Anemia, Heart Failure, Dementia, Depression with Behavioral Disturbances, Alzheimer's Disease and Urge Incontinence.</p> <p>Review of the MDS Admission Assessment dated 6/14/15 revealed the resident required extensive assistance with toileting and was frequently</p>	F 315	<p>period will be monitored by MDS nurse for a decline in bladder function, completion of voiding diary, and individualized toilet program weekly for 4 weeks. Then, ADON will monitor 6 new residents and 6 residents in MDS look-back period monthly for 12 months. DON will be notified of results of monitoring and results will be reported to the QAPI Committee.</p>	11/18/2015	

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F 315	Continued From page 14 incontinent. Review of the MDS Quarterly Assessment dated 8/31/15 revealed the resident was total dependence for toileting and was always incontinent of urine. Further review revealed a toileting program had not been attempted. Interview with LPN #4 on 10/21/15 at 8:48 AM, in the 8 East Nurses Station, revealed the resident was always incontinent of urine. Continued interview revealed "we do not do 3 day bladder pattern assessment." Interview with MDS Coordinator on 10/21/15 at 9:41 AM, in the MDS Coordinator's office, revealed there was no documentation of a bladder pattern assessment on admission or reassessment of bladder pattern with a change in urinary incontinence. Interview with the Interim DON on 10/21/15 at 1:06 PM, in the DON's office, revealed the residents were "supposed to be evaluated for bowel and bladder patterns." Continued interview confirmed the facility failed to complete a bladder pattern assessment on admission and with the resident's change in urinary incontinence status as iridicated by facility policy.	F 315			
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES 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.	F 319	F319 483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES 1. Resident # 57's family and physician were notified of resident's change of behavior. Resident went to neurologist and received medication adjustment for behaviors. 2. DON reviewed behavior monitoring sheets, 24-hour reports, nursing documentation and found that residents with behavior changes had		

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F 319	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to address behavioral changes to determine appropriate treatment and services for one resident (#57) of 3 residents reviewed for behavior disturbance of 29 sampled residents. The findings included: Medical record review revealed Resident #57 was admitted to the facility on 7/24/15 and readmitted on 9/17/15 with diagnoses including Depressive Disorder, Dementia without Behavioral Disturbances, Dementia with Lewy Bodies, Anxiety, and Dysphagia. Observation on 10/21/15 at 9:04 AM, in the resident's room, revealed Resident #57 was dressed sitting in his wheelchair and picking up a pillow off the floor. Observation on 10/21/15 at 1:36 PM, in the resident's room, revealed resident #57 was sitting in the wheelchair talking to his wife. Medical record review of the Nursing Interdisciplinary Progress Note dated 10/2/15 revealed, "...Late entry: 10-01-2015...While changing resident he became very agitated and was grabbing cna [Certified Nursing Assistant] and twisting her arm..." Medical record review of the Care Plan dated 10/1/15, revealed "...has impaired behavior related to becoming agitated when his needs are not immediately met by staff...I will demonstrate	F 319	appropriate treatment/services implemented. 3. Review of system identified that residents did not receive appropriate behavior treatment/services due to change in DON/ADON and Nurse Managers. Director of Quality or designee educated (Attachment #7A) nurses/CNAs concerning identifying and reporting behavioral changes and ensuring appropriate referral for treatment and services for behavioral changes. RN Managers will review 24-hour report (Attachment #7B) daily to identify resident with any change of behaviors and ensure that proper referrals for resources/treatments have been offered. 4. Social Services and Interdisciplinary Team will monitor (Attachment #7C) behavioral changes for appropriate treatment and services in weekly behavior meeting. This information will be reported monthly for 12 months at QAPI meeting and act on any directives corresponding to audit outcomes.	11/18/2015	

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F 319	Continued From page 16 optimal ADL [Activities of Daily Living] functioning and safety..." Medical record review of the Nursing Interdisciplinary Notes dated 10/5/15 revealed, "...resident was sitting on the side of the bed again this time he became very agitated and...was twisting my arm and fingers..." Medical record review of Physician orders dated 10/20/15 revealed no documentation of changes in the resident's treatment plan after the behavioral changes on 10/1/15 and 10/5/15. Interview with the Interim Director of Nursing on 10/21/15 at 11:01 AM, in the 8th floor hallway, revealed, "The physician was not at the morning meeting when the resident was discussed and his treatment was not changed." Further interview confirmed the facility failed to address new behavioral disturbances on 10/1/15 and 10/5/15.	F 319		
F 323 SS=G	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 facility	F 323	F323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 1. Resident #153 was discharged. Resident #104 care plan reviewed with staff. Resident #104 was not harmed during transfer. CNA #1 terminated on 9/1/15. CNA #2 counseled and educate by ADON on following care plan for transfers.	

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F 323	<p>Continued From page 17</p> <p>documentation, interview, and observation, the facility failed to prevent a fall for one resident (#153), resulting in Harm to the resident, and failed to provide the appropriate number of staff assistance for transfers for one resident (#104) of 6 residents reviewed for falls of 29 residents sampled.</p> <p>The findings included:</p> <p>Medical record review revealed Resident #153 was admitted to the facility on 6/10/15 with diagnoses including Aspiration Event, Aspiration Pneumonitis, Chronic Atrial Fibrillation, Dementia, Alzheimer's Disease, and Difficulty Walking.</p> <p>Medical record review of the resident's Minimum Data Set [MDS] dated 6/17/15 revealed the resident had cognitive impairment, memory problems, and required extensive assistance with transfers and ambulation.</p> <p>Medical record review of a nurse's note dated 6/27/15 revealed, "...called to resident's room at 1:20 AM by CNA [certified nursing assistant]. Resident found lying on her R [right] side on floor next to bed...unable to answer what happened or if she hit head...call made to Dr [doctor]...to update on resident condition. Order received to send to...hospital...for evaluation and treatment..."</p> <p>Review of the facility documentation of the fall dated 6/27/15 revealed interventions were in place at the time of the fall and included a low bed and nonskid socks.</p> <p>Medical record review revealed Resident #153 was readmitted back to the facility on 7/4/15 with diagnoses including Aftercare for Healing</p>	F 323	<p>2. Identified that changes in transfer status were not being communicated well from therapy staff to nursing staff to update plan of care and care profile to prevent accidents. Audit completed on 11/11, by therapy staff of all residents for appropriate transfer status and number of staff. Residents identified as such had care plans updated to appropriate transfer status and number of staff.</p> <p>3. DON/ADON or designee educated (Attachment #8A) staff on how to locate transfer status; this was added to 24-hour report (Attachment #8B). Interdisciplinary communication form will be completed by therapy and given to the nursing staff, with copy given to MDS to verify status was updated in care plan. 24-hour report will be updated nightly by nurses according to care plan.</p> <p>4. DON or designee will observe (Attachment #8C) 6 resident transfers per care plan weekly for 4 weeks. Then, DON or designee will observe 6 resident transfers per care plan</p>		

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F 323	<p>Continued From page 18</p> <p>Traumatic Left Hip Fracture, Dementia, Atrial Fibrillation, and Muscle Weakness.</p> <p>Medical record review of the resident's plan of care dated 7/4/15 revealed "...need 2 person staff assistance with transfers...support with transfer with use of Hoyer lift [type of total dependence non weight bearing lift]..."</p> <p>Medical record review of the Physical Therapy Evaluation and Plan of Treatment with a start date of 7/5/15 revealed, "...Transfers= [equals] Total Dependence w/o [without] attempts to initiate unable to perform sit to stand despite max [maximum] assist of 2...patient will require use of total dependence lift for OOB [out of bed transfer]..."</p> <p>Medical record review of a nurse's note dated 7/6/15 revealed, "...@ [at] 1130 [11:30 AM] CNA and this nurse was transferring resident to restroom using the sit-to-stand lift [type of weight bearing lift]...Encouraging resident to bear weight on her right leg and toe touch with the left. Resident was cooperative and then suddenly said no and let go of the lift crossing her hands losing her balance in the lift. CNA and [charge nurse] assisted resident by lowering her to the floor...Assisted resident back to wheelchair x3 [with 3] staff members and then assisted resident to bed with assist from PT [Physical Therapy] department..."</p> <p>Medical record review of a nurse's note dated 7/7/15 at 1:11 AM revealed, "...Assessment of surgical site shows severe redness and warmth to 2 staples on left hip...Middle site has 2 inch surrounding area that is hard and red. Will alert day shift nurse of need to call surgeon in AM</p>	F 323	<p>monthly for 12 months. This information will be reported at monthly QAPI meeting and act upon any directives corresponding to audit outcomes.</p>	11/18/2015	

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F 323	<p>Continued From page 19 [morning]..."</p> <p>Medical record review of a nurse's note dated 7/7/15 at 10:13 AM, revealed, "...On assessment of surgical site distal from hip is red, hard, swollen, 2 inches by 2 inches...Md [Medical Doctor] called and informed. With new orders to apply warm compresses to area for 20 minutes...will continue to monitor..."</p> <p>Medical record review of a Physicians telephone order dated 7/8/15 revealed, "...x-ray to left hip and femur...pain..."</p> <p>Medical record review of a mobile image of the left hip dated 7/8/15 revealed, "...Findings: screw threads projecting beyond the superior margin of the femoral neck and appearing to impinge upon the lateral aspect of the acetabulum...Impressions: Recurrent fracture of the femoral neck versus malposition dynamic screw of the femoral neck...notified Dr...wants to see resident on...7/10/15..."</p> <p>Medical record review of a nurse's note dated 7/10/15 at 10:34 AM revealed, "...Left for Dr. appointment at 1015 [10:15 AM]..."</p> <p>Medical record review of a Hospital Consultation Report dated 7/10/15 revealed "...recently fell...status post placement of an IM [intramedullary nail] nail to...left femur and was admitted to the hospital today for revision to a total hip arthroplasty on that side..."</p> <p>Medical record review of the Hospital Discharge summary dated 7/12/15 revealed discharge diagnoses included "...1. Status post fall. with a recurrent hip fracture. History of recent hip</p>	F 323			

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F 323	<p>Continued From page 20 fracture. status post surgery. Second fall with a new hip fracture..."</p> <p>Interview and medical record review of the plan of care with the MDS coordinator on 10/21/15 at 1:20 PM, in the MDS office, confirmed the resident was to have a Hoyer lift for transfer.</p> <p>Interview and review of the physical therapy evaluation and plan of treatment with the Physical Therapist on 10/21/15 at 1:27 PM, in the therapy room, confirmed the resident required a total dependence lift for transfers.</p> <p>Telephone interview with Licensed Practical Nurse (LPN) #3 on 10/21/15 at 1:12 PM, revealed the LPN did not look at the resident's plan of care prior to transferring the resident. Continued interview revealed the LPN used a sit-to stand lift instead of the Hoyer lift identified for use with the resident by therapy and nursing staff.</p> <p>Interview with the Medical Director on 10/21/15 at 12:48 PM, in the conference room, confirmed the resident's fall could have caused the re-injury to the resident's hip.</p> <p>Interview with the Interim Director of Nursing (DON) on 10/21/15 at 2:10 PM, in the DON office, confirmed the facility failed to prevent a fall, resulting in harm to the resident, by not using the appropriate lift for transfer of the resident.</p> <p>Medical record review revealed Resident #104 was admitted to the facility on 8/12/15 with diagnoses including Pneumonia, Hemiplegia Affecting Dominant Side, Aphasia, History of Fall, Atrial Fibrillation, Chronic Kidney Disease Stage 3, Major Depressive Disorder, and Dysphagia.</p>	F 323		
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F 323	<p>Continued From page 21</p> <p>Medical record review of an admission nurse's note dated 8/12/15 revealed, "...resident requires max [maximum] assist with all ADLs [activities of daily living]..."</p> <p>Medical record review of the Admission MDS dated 8/19/15 revealed the resident scored an 8 on the Brief Interview for Mental Status (BIMS) indicating the resident was moderately cognitively impaired. Continued review revealed the resident required extensive assistance of 2 persons for bed mobility, transfer, dressing, and personal hygiene. Further review revealed the resident was only able to stabilize with the assistance of staff, and had limitation in range of motion in upper and lower extremities.</p> <p>Review of facility documentation dated 8/30/15 revealed Resident #104 had reported to the facility the resident had requested assistance with toileting on the evening of 8/29/15. Continued review revealed the resident stated CNA #1 had responded to the resident's request for assistance with getting to the toilet. Further review revealed the CNA had transferred the resident from the bed to a wheelchair, from the wheelchair to the toilet, and then back to the resident's bed. Further review revealed the resident stated the CNA then "...rushed me in the w/c [wheelchair] into the room and he dumped me into my bed..." Continued review revealed the resident struck her head on the side rail of the bed during the transfer from the wheelchair back to the bed. Further review revealed the resident was not injured during the transfer.</p> <p>Review of a witness statement signed and dated on 9/1/15 by CNA #1 revealed the CNA had</p>	F 323		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/21/2015
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NAME OF PROVIDER OR SUPPLIER ALEXIAN VILLAGE OF TENNESSEE	STREET ADDRESS, CITY, STATE, ZIP CODE 671 ALEXIAN WAY SIGNAL MOUNTAIN, TN 37377
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F 323	<p>Continued From page 22</p> <p>transferred the resident without the assistance of another staff member.</p> <p>Medical record review of the resident's nursing care plan, last updated on 10/2/15, revealed "...needs assistance with daily ADL care; she is new admission to facility...I need 2 staff support with transfer...I need max assistance with mobility. I need 2 staff support with mobility...I need 2 staff support with bed mobility...I need 2 staff support with toileting..."</p> <p>Medical record review of Resident ADL/Daily Care List (Certified Nurse Assistant care plan) last updated on 10/2/15, revealed "...Transfers and Ambulation/Mobility: Gait Belt, Resident requires max assist for transfers x [times] 2 assist..."</p> <p>Interview with Resident #104 on 10/20/15 at 8:17 AM, in the resident's room, revealed the resident had called for assistance with getting to the toilet on the evening of 8/29/15. Continued interview revealed CNA #1 had transferred the resident from the bed to the wheelchair, had taken the resident to the toilet, and then transferred the resident back to the bed. Continued interview revealed the resident felt as if CNA #1 had "...acted like he did not know what he was doing, stepped on my feet..." and had caused the resident to become fearful she was going to fall during the transfer. Further interview revealed when the CNA had transferred the resident back to the bed the CNA had "...dumped..." the resident in the bed causing the resident to hit her head on the side rail. Further interview confirmed CNA #1 had transferred the resident without the assistance of another staff person.</p>	F 323		
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NAME OF PROVIDER OR SUPPLIER ALEXIAN VILLAGE OF TENNESSEE			STREET ADDRESS, CITY, STATE, ZIP CODE 671 ALEXIAN WAY SIGNAL MOUNTAIN, TN 37377		
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F 323	<p>Continued From page 23</p> <p>Observation on 10/20/15 at 4:20 PM, in the resident's room, revealed CNA #2 was preparing to transfer Resident #104 from the resident's bed to the resident's wheelchair to assist in getting to the toilet. Continued observation revealed CNA #2 took the resident to the bathroom and had assisted the resident from the wheelchair to the toilet by herself.</p> <p>Interview with LPN #5 on 10/20/15 at 4:25 PM, in the 7 West Nurse Station, revealed the CNAs were kept informed of the level of assistance a resident required for transfers through reviewing the resident's ADL/Daily Care List care plan or by asking the nurses. Continued interview revealed Resident #104 was documented as requiring the use of 2 staff members for transfers. Further interview revealed the LPN had been present on 8/30/15 when the resident had complained regarding CNA #1 transferring the resident without assistance to the toilet and back to bed. Continued interview confirmed CNA #1 had transferred the resident without the assistance of another staff person. Continued interview confirmed CNA #2 transferred the resident without assistance of another staff person on 10/20/15 at 4:20 PM.</p> <p>Interview with the Interim DON on 10/21/15, at 1:41 PM, in the Conference Room, revealed CNAs were required to read and acknowledge they have read the resident's ADL/Daily Care List which instructs CNAs on the level of assistance needed for transfers. Continued interview confirmed Resident #104 was documented on both the nursing and CNA care plan as requiring the use of 2 staff members for transfers. Continued interview confirmed the resident had required the assistance of 2 people for transfers</p>	F 323			

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F 323	Continued From page 24 on both 8/30/15 and on 10/20/15. Further interview confirmed both CNA #1 and CNA #2 had failed to provide the required level of assistance during transfers.	F 323	F332 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% <ol style="list-style-type: none"> 1. Resident #103 had no harm related to medication error. LPN #2 was educated on appropriate use of Spiriva and Flovent inhaler. 2. DON reviewed residents receiving inhalers and observed administration by nurses. No deficient practices were observed and no other residents were affected. 3. Omnicare pharmacist and DON in-serviced (Attachments #9A & #9B) nurses on 11/4/2015 on administration of inhalers. A follow-up in-service for nurses will be provided on 11/18/2015. 4. DON or designee will observe (Attachment #9C) 2 medication passes per week for 4 weeks focusing on use of inhalers. Then, 1 medication pass per week for 4 weeks focusing on use of inhalers. Then 2 medication passes per month for 1 month focusing on use of inhalers. Then 1 Medication pass per month for 9 months. Results will be reported monthly to the QAPI Committee. 		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, observation, and interview, the facility failed to demonstrate a medication error rate below 5% for 2 errors observed of 26 opportunities, for 1 of 3 nurses observed during medication pass on 1 of 3 halls, resulting in a medication error rate of 7%. The findings included: Review of the facility policy for Inhalers revealed "...if two inhalations are prescribed, wait at least 1 minute between them. If you are using other inhalers at the same time, wait at least 1 minute between the use of each medication..." Medical record review revealed Resident #103 was admitted to the facility on 7/2/12 with diagnoses including Pneumonia, Chronic Obstructive Pulmonary Disease, and Congestive Heart Failure. Medical record review of the resident's recapitulation orders for October 2015 revealed,	F 332			11/18/2015

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F 332	<p>Continued From page 25</p> <p>"...Spiriva [type of inhaled medication]...once every day...wait at least 1 minute between each inhaled medication...Flovent [type of inhaled medication]...2 puffs by mouth twice daily wait 1 minute between puffs..."</p> <p>Observation of Licensed Practical Nurse (LPN) #2 on 10/21/15 at 7:59 AM, on the 800 west hall, revealed the LPN administered the Flovent to Resident #103, did not wait 1 minute between each puff, and immediately administered the Spiriva.</p> <p>Interview with LPN #2 on 10/21/15 at 8:10 AM, in the 800 west hall medication room, confirmed the LPN did not wait between each puff or each inhaled medication prior to administration.</p> <p>Interview with the Interim Director of Nursing (DON) on 10/21/15 at 3:00 PM, in the Administrator's office, confirmed the facility policy was not followed for use of inhalers.</p>	F 332		
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