

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

POE # 2 Acceptable

No. 0652

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  08/06/2014
NAME OF PROVIDER OR SUPPLIER  ALEXIAN VILLAGE OF TENNESSEE			STREET ADDRESS, CITY, STATE, ZIP CODE 671 ALEXIAN WAY SIGNAL MOUNTAIN, TN 37377		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 204 SS=D	<p>483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG</p> <p>A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.</p> <p>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.75(r).</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide discharge information at the time of discharge to one resident (#149) of three residents reviewed for discharges.</p> <p>The findings included:</p> <p>Resident #149 was admitted to the facility on June 11, 2014, with diagnoses including Congestive Heart Failure, Hyperthyroidism, Pressure Ulcer, and Diabetes Mellitus. Resident #149 was discharged to home on July 8, 2014.</p> <p>Interview on August 6, 2014 at 9:28 a.m., with Assistant Director of Nursing (ADON) #1, in the facility conference room, revealed the Charge Nurse responsible for discharging resident #149 on July 8, 2014, failed to give the discharge paperwork to the resident's family at discharge. Continued interview revealed the Charge Nurse stated tried to contact the family, and could not</p>	F 204	<p>Alexian Village of Tennessee Healthcare 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.</p> <p>Disclaimer Statement Alexian Village of Tennessee Healthcare and Rehabilitation Center does not admit that any deficiencies existed, before, during or after the survey, Alexian Village of Tennessee Healthcare 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 of Tennessee Healthcare 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 of Tennessee Healthcare and Rehabilitation Center does not waive.</p> <p>F204 483.12(r)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER DISCHRG</p> <p>Resident #149 discharged from the facility. The resident case was provided as an example for nursing staff education in regard to discharging residents with medications or prescriptions, providing written discharge instructions, and follow up instructions before or at the time of discharge. Residents discharged from the community 2 weeks prior to effected resident were reviewed for compliance and none were affected. All discharges will be monitored for the first 30 days by DON, ADON, or designee, and then a sample will be reviewed monthly. The discharge process will be reviewed by the QAA Committee at least quarterly for the 1<sup>st</sup> two quarters then random review to ensure ongoing compliance. (continued next page)</p>	09/01/14	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE 9/16/14

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 204	<p>Continued From page 1</p> <p>get the family on the phone. The Charge Nurse then contacted a friend of the family, who worked at the facility and gave a copy of the discharge paperwork to deliver to the resident.</p> <p>Interview on August 6, 2014, at 10:41 a.m., with Physical Therapist (PT) # 1, by phone revealed the charge nurse contacted the PT and asked to take the discharge paperwork to the family, after the Charge Nurse was unable to reach the family by telephone.</p> <p>Interview and review of the Post Discharge Plan of Care dated July 8, 2014, with Charge Nurse #4 on August 6, 2014, at 2:05 p.m., in the Social Services office, revealed no documentation of an appointment scheduled or prescriptions obtained. Continued Interview with the Charge Nurse confirmed the Charge Nurse assumed the resident was going to a facility that provided medications or would have obtained prescriptions prior to discharge from the facility. Continued interview revealed the Charge Nurse stated attempted to call the family four times with no answer and then contacted the PT who stated he/she would give the medication list to the family.</p> <p>Interview with the Director of Nursing (DON) on August 6, 2014, at 2:38 p.m., in the DON office, confirmed the facility failed to ensure the resident prescriptions were obtained, failed to obtain a follow up doctor appointment, and failed to give written discharge instructions to the resident prior to discharge from facility.</p> <p>C/O # 34375</p>	F 204	<p><b>F244 483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION</b></p> <p>Residents #32, #46, #47, #110, #113 and #134 grievances about the palatable foods were immediately addressed by dietary services and fixed to the resident's satisfaction.</p> <p>No other residents were affected.</p> <p>Resident or family grievances will be documented and provided to the appropriate department manager for action and resolution. Grievances will be received by any staff and provided to Social Services for documentation, distribution and resolution. Social Services will follow up grievances to ensure an effective resolution in incorporated and communicated to the resident/family.</p> <p>The QAA committee will monitor the grievance record quarterly for compliance.</p>	09/01/14
F 244	483.15(c)(6) LISTEN/ACT ON GROUP	F 244		

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F 244 SS=E	<p>Continued From page 2  <b>GRIEVANCE/RECOMMENDATION</b></p> <p>When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p> <p>This REQUIREMENT is not met as evidenced by:                  Based on interview and review of the Resident Council minutes, the facility failed to resolve grievances related to palatable food for six residents (#32, #46, #47, #110, #113, #134) of twenty-four residents reviewed.</p> <p>The findings included:</p> <p>Review of resident council minutes for February, May, and July 2014, revealed residents concerned with the food. Continued review revealed no documentation of food concerns resolved.</p> <p>Interviews on August 4 through 6, 2014, with resident #32, #46, #47, #110, #113, and #134 revealed food is not palatable, too spicy, or hard to chew. Continued interview on August 6, 2014, confirmed food has not improved.</p> <p>Interview with the Resident Council members (Residents #47 and #100-roommates) on August 6, 2014, at 9:30 a.m., in the residents' room, revealed, the facility had not responded to grievances regarding food quality.</p> <p>Review of the Resident Council minutes and</p>	F 244		
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F 244	Continued From page 3 interview with the Activities Director, on August 6, 2014, at 12:10 p.m., in the Activities office, confirmed the Resident Council members had voiced concerns about food quality in February, May, and July 2014, and the facility had failed to resolve those grievances.	F 244		
F 323 SS=D	<b>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b>  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 the facility policy, and interview, the facility failed to implement new interventions after two falls for one resident (#77) of three residents reviewed for falls of twenty-two sampled residents.  The findings included:  Resident #77 was admitted to the facility on March 3, 2014, with diagnoses including Anorexia, Postural Hypotension, Debility, Depression, and Right Knee Replacement.  Review of the Admission Minimum Data Set (MDS) dated March 9, 2014, and the Quarterly MDS dated June 4, 2014, revealed the resident was non-ambulatory and required the assistance of two plus persons for transfers. Further review	F 323	<b>F323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b>  Resident #77's plan of care and incident action plan was reviewed and documented to ensure resident's action plan to prevent accidental hazards is followed, as is possible and receives adequate supervision or assistive devices to prevent further incidents.  A review of all residents on each floor was conducted and no other residents were affected.  Staff education was provided (during the survey) to all nursing staff in fall prevention priority, proper use of preventive devices and appropriate information is documented every shift. All preventive devices are recorded on the Medication Administration Record (MAR) and monitored daily. Orders and documentation are checked monthly to ensure documentation is reflected month to month.  The DON or designee will report efficacy of procedure to the QAA Committee quarterly.	09/01/14

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F 323	<p>Continued From page 4 revealed the resident had periods of confusion.</p> <p>Review of the fall investigation dated May 30, 2014, 9:30 a.m., revealed an unwitnessed fall without injury from a low bed to the floor mat. Continued review revealed the interventions in place at the time of the incident were floor mat, low bed, scoop mattress, and quarter side rails. Continued review revealed the new intervention to be implemented post fall was a bed pressure alarm.</p> <p>Review of the fall investigation dated June 25, 2014, 4:00 a.m., revealed an unwitnessed fall without injury from a low bed to the floor mat. Continued review revealed interventions in place at the time of the incident were floor mat, low bed, scoop mattress, and quarter side rails. Continued review revealed the new intervention to be implemented post fall was a bed pressure alarm. Further review revealed no documentation the bed alarm was in place at the time of the fall on June 25, 2014.</p> <p>Review of the fall investigation dated June 30, 2014, 10:20 p.m., revealed an unwitnessed fall without injury from a low bed to the floor mat. Continued review revealed the interventions in place at time of the incident were bed pressure alarm, floor mat, low bed, and quarter side rails. Continued review revealed the new intervention to be implemented post fall was a bed bolster (a long cushioned support).</p> <p>Review of fall investigation dated July 6, 2014, 4:30 p.m., revealed an unwitnessed fall without injury from a low bed to the floor mat. Continued review revealed the interventions in place at the time of incident were bed pressure alarm</p>	F 323		
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F 323	<p>Continued From page 5 (sounded at fall), low bed, floor mat, scoop mattress, quarter side rails. Continued review revealed the new intervention to be implemented was a bolster. Further review revealed no documentation of bolster being in place at the time of fall on July 6, 2014.</p> <p>Review of the undated facility policy, Fall Management, revealed "...Procedures: Post fall...Immediately after the fall implement fall precaution interventions..."</p> <p>Interview with Assistant Director of Nursing #1 at 2:05 p.m., on August 6, 2014, in the sixth floor chapel, confirmed the facility failed to implement the new fall precautions for resident #77 after the falls on May 30, 2014, and June 30, 2014.</p>	F 323		
F 371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and interview, the facility failed to store or serve food under sanitary conditions.</p> <p>The findings included:</p>	F 371	<p>F371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY</p> <p>Dining staff members were corrected and applied appropriate hair covering. Food items that were not labeled or uncovered were properly disposed. The dining aide was educated on the proper sanitation of the thermometer while checking food temperatures.</p> <p>Staff education was provided to all dining staff by the Dining Director and/or designee in proper labeling, covering and discarding out of date foods. Additional education was provided to dining staff in sanitation procedures including the use of hair covering devices.</p> <p>Dining Director or designee will monitor food storage, use of hair covering as well as sanitation procedures daily.</p> <p>The Dining Director or designee will report efficacy of procedure to the QAA Committee quarterly.</p>	09/01/14

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F 371	<p>Continued From page 6</p> <p>Observation on August 4, 2014, at 11:15 a.m., in the kitchen, revealed three dietary staff members without hair covering.</p> <p>Observation on August 4, 2014, at 11:30 a.m., during the initial kitchen tour, revealed three out of seven freezers contained undated or uncovered items. The meat freezer contained an open, undated bag of shrimp, with one shrimp lying outside of the bag; the ice cream freezer contained an open, undated forty-eight ounce carton of pineapple ice cream; the produce freezer contained an undated sheet cake and twenty-three cups of pureed cake dated August 1, 2014.</p> <p>Observation of the sixth floor dining room steam table, at 12:25 p.m., on August 4, 2014, revealed Dietary Aide #1 wiped the food thermometer with an alcohol wipe, obtained a napkin from the top of the microwave, checked the temperature of the first food item with the thermometer, and then proceeded to wipe the thermometer with the napkin. Continued observation revealed Dietary Aide #1 checked temperatures of each food item, wiped thermometer with the napkin without using a sanitizing agent on eight out of eight food items.</p> <p>Review of the "Touchpoint Hourly Associate Handbook", under "Associate Conduct: Personal Appearance/Hand Washing", revised June 2013, revealed "... As part of the food service uniform, hair must be covered by a hair net or a hat that has been approved for use by the Company...".</p> <p>Review of the policy for "Food Storage Chart", under policy #B006, revealed "...unused portions...prepared on site, such as recipes that</p>	F 371		
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Sep. 16. 2014 11:37AM  
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No. 0652 PRP. 9D: 08/11/2014  
 FORM APPROVED  
 OMB NO. 0938-0391

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F 371	Continued From page 7 contain meat, milk, eggs, cheese, raw vegetables, and fresh fruit..." are considered expired after two days of preparation date.  Review of the policy for "Meal Temperature Record", under "Resident Food Services", revised March 2011, revealed "...sanitize the thermometer in an approved sanitizing solution or product prior to starting the process and after testing each food item...".  Interview with Assistant Dietary Manager (ADM), at 4:00 p.m., on August 4, 2014, in the kitchen, confirmed the staff members were not wearing hair coverings; the shrimp was open and undated in the meat freezer, and should be tossed; the open carton of pineapple ice cream in the ice cream freezer was undated; the sheet cake was not dated, and the twenty-three cups of pureed cake dated August 1, 2014, were outdated and should have been consumed or discarded by August 3, 2014.  Interview with ADM, and Dietary Aide #1, at 5:00 p.m., on August 5, 2014, in the sixth floor dining room, confirmed the aide did not follow proper procedure when wiping the thermometer in between checking temperatures for each item on eight out of eight food items, and confirmed thirty-nine residents were served after the temperature checks.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431	F431 483.60(b), (d), (e) DRUGS RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The identified refrigerator was replaced (during the survey) and all affected medications were destroyed and reordered.  No residents were affected.  Staff education was provided by DON or designee to all nursing staff in regard to recording and monitoring refrigerator temperatures daily, each shift and instructed to report temperatures outside the acceptable range of 36-46 degrees Fahrenheit.  The DON or designee will report efficacy of procedure to the QAA Committee quarterly.	09/01/14

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F 431	<p>Continued From page 8</p> <p>accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, review of the refrigerator temperature log, facility policy review, and interview, the facility failed to store medications according to the manufacturer's recommendations for one of two medication refrigerators observed.</p>	F 431		
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F 431	<p>Continued From page 9                  The findings included:</p> <p>Observation on August 6, 2014, at 10:25 a.m., of the thermometer in the refrigerator located in the 7th floor medication room, with Licensed Practical Nurse (LPN) #3, revealed the refrigerator's temperature was 24 degrees Fahrenheit (F), with visible ice build-up in the freezer portion of the refrigerator. Continued observation revealed multiple medications were stored in the refrigerator.</p> <p>Observation and inventory of the contents from the refrigerator on August 6, 2014, at 10:30 a.m., with Registered Nurse (RN) #1, revealed the following medications stored in the refrigerator: Biscodyl 10 milligram (mg) suppositories x (times) 43 (without storage information); Tylenol 650 mg suppositories x 55 with storage instructions to store medication between 68 degrees F and 77 degrees F; Phenadoz 12.5 mg suppository x 2 and Phenadoz 25 mg suppository x 12 with package labelling to store medication between 36 degrees F and 46 degrees F; an opened vial of Tubersol Solution 1 milliliter (ml) vial, partially used, with package labelling to store medication at 36 degrees F to 46 degrees F; Latanoprost 0.005% ophthalmic solution, 2.5 ml bottle unopened with package labelling to store at 36 degrees F to 46 degrees F; Novolog Insulin 100U/ml, 10 ml vial, unopened x 2 with package labeling, "...Keep In cold place. Avoid freezing..."; Lantus Insulin 10 ml vial, unopened, x 2 with a package insert for storage instructions, "...LANTUS should not be stored in the freezer and should not be allowed to freeze. Discard LANTUS if it has been frozen..."; Travatan ophthalmic solution 0.004%, 2.5 ml bottle, unopened, x 2 with storage instructions to store at</p>	F 431		
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F 431	<p>Continued From page 10</p> <p>36 degrees F to 77 degrees F; Performist 20 micrograms (mcg) per 2 ml Inhaler x 3 with package labelling to store at 35 degrees F to 77 degrees F; Restasis 0.05% ophthalmic solution, 0.4 ml per dose, x 5 boxes each containing 30 doses with package instructions to store medication at 59 degrees F to 77 degrees F.</p> <p>Observation and interview on August 6, 2014, at 3:30 p.m., with LPN #2, in the 6th floor medication room, confirmed with the Biscodyl package labelling that the suppositories should be stored at room temperature.</p> <p>Review of the 7th floor refrigerator temperature monitoring log dated July 2014, revealed, "Appropriate Refrigerator Range = 36 degrees F to 46 degrees F...In the event that the refrigerator and/or freezer temperature are not within the accepted range, staff shall IMMEDIATELY NOTIFY a manager or nursing leader who will seek consultation to determine if medications and antigens remain viable."</p> <p>Continued review of the refrigerator temperature monitoring log revealed twenty-nine temperature results of thirty opportunities for monitoring refrigerator temperatures were below the facility's established "Appropriate Refrigerator Range of 36 degrees F..."</p> <p>Review of the refrigerator log for August 2014, revealed, four temperature results of five opportunities for monitoring refrigerator temperatures were below the appropriate refrigerator range of 36 degrees F.</p> <p>Review of the facility's policy, Refrigerator, revealed, "...Purpose: Maintain refrigerator</p>	F 431		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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  08/06/2014
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NAME OF PROVIDER OR SUPPLIER  ALEXIAN VILLAGE OF TENNESSEE	STREET ADDRESS, CITY, STATE, ZIP CODE 871 ALEXIAN WAY SIGNAL MOUNTAIN, TN 37377
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 431	<p>Continued From page 11 cleanliness and temperature..."</p> <p>Interview with the Director of Nursing (DON) in the DON's office on August 6, 2014, at 2:20 p.m., confirmed the facility had not maintained the refrigerator temperature in accordance with the facility's policy, and the medications had not been stored per manufacturer's recommendations.</p>	F 431		
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