RECEIVED

JUN 10 2016

PRINTED: 05/27/2016
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
C TERS FOR MEDICARE & MEDICAID SERVICES

S. ENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445470	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 01/27/2016
NAME OF PROVIDER OR SUPPLIER BENCHMARK HEALTHCARE OF PURYEAR INC		STREET ADDRESS, CITY, STATE, ZIP CODE 220 COLLEGE STREET PURYEAR, TN 38251	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS AMENDED 2567 The re-certification survey was conducted on 1/25/16 through 1/27/16 with an extended survey completed on 1/27/16. The survey team identified Substandard Quality of Care and actual harm level deficiencies related to prevention of accidents. The re-certification survey was found to have Substandard Quality of Care and harm level deficiencies cited at F280 G, F282 G, F323 H, F490 H, F501 H, and F502 H. The failure to implement a new intervention after each fall resulted in actual harm when Resident #26 fell again sustaining a left hip fracture on 6/29/15.	F 000	6/10/16 acceptable POC SWehner	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual	F 278	MDS for Resident #24 dated 09/24/15 and 12/24/15 were reviewed/ revised by MDS Coordinator on 02/15/2016 to reflect correct coding of number of days resident received antibiotics and number of falls with injury. Revised MDS were submitted to CMS on 02/15/16 and accepted. All MDS Sections N0410 and J1900 on all residents with MDS's completed in the last 3 months (November 2015, December 2015, and January 2016) were reviewed by the MDS Coordinator and audited for accuracy on 02/15/2016 and 02/16/2016. Any MDS s that required a modification to correct sections N0410 and J1900 were revised by the MDS Coordinator on 02/15/2016 and 02/16/2016. Modified MDS's were transmitted and accepted on 02/17/2016.	021714

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen Lascaste | TITLE: LWHA | (X6) DATE: 021914

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.

Karen Lascaste LWHA Revised 060714

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 278	Continued From page 1 to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to accurately assess a resident for antibiotics and falls for 1 of 21 (Resident #24) sampled residents included in the stage 2 review. The findings included: Medical record review revealed Resident #24 was admitted to the facility on 9/11/15 with diagnoses of Alzheimer's Disease, Anxiety Disorder, Chronic Obstructive Pulmonary Disease, Hypertension, Psychotic Disorder, Enlarged Prostate, and Lower Urinary Tract Symptoms. The admission Minimum Data Set (MDS) dated 9/24/15 documented, "...Medications Received... Enter Days 7... Antibiotic..." The Medication Administration Record (MAR) documented, "...Augmentin Tablet 875-125 MG [milligrams]... 1 tablet by mouth two times a day..." and was documented as being administered on 9/18/15, 9/19/15, 9/20/15 at 0800 and 2000, and on 9/21/15 at 0800. Resident #24 only received antibiotics on 4 days. Interview with the MDS Coordinator on 1/27/16 at 1:30 PM, in the therapy department, the MDS	F 278	The MDS Coordinator was In-serviced on MDS Sections N0410 and J1900 using the CMS RAI 3.0 Manual on 02/15/2015 by the Director of Nursing. MDS Coordinator will use the MDS Data Collection Sheet to collect information on all MDS completed to ensure accuracy of the Information. Any future noncompliance in MDS accuracy will be reported to the Quality Assurance Improvement Committee by the MDS Coordinator or her designee for Immediate action to resolve the issue.	02/7/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445470	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 01/27/2016
NAME OF PROVIDER OR SUPPLIER BENCHMARK HEALTHCARE OF PURYEAR INC		STREET ADDRESS, CITY, STATE, ZIP CODE 220 COLLEGE STREET PURYEAR, TN 38251	

(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 278	Continued From page 2 Coordinator was asked to verify the number of days the antibiotic was given. The MDS Coordinator stated, "Received antibiotic for 4 days. I guess I didn't know what I was looking at." The MDS Coordinator was asked how many days the MDS should have been coded for the antibiotic. The MDS Coordinator stated, "Four days. I take full blame for this." The quarterly MDS dated 12/24/15 documented, "...Number of Falls Since Admission / Entry or Reentry or Prior Assessment... 2... No injury... 0... Injury / except major)..." The fall investigation report dated 9/29/15 documented, "...Resident's body alarm was going off and CNA [Certified Nursing Assistant] went to check on resident and resident was lying in [on] the floor on his right side. Skin tear noted to right knee..." The fall investigation report dated 10/24/15 documented, "...Residents body alarm sounding. Went to residents room and found resident sitting in [on] floor on mat next to bed... Injury Type Abrasion Injury Location... Right knee..." Interview with the MDS Coordinator on 1/27/16 at 1:30 PM, in the therapy department, the MDS Coordinator was asked to verify the number of falls the resident had for the MDS dated 12/24/15. The MDS Coordinator verified Resident #24 had an skin tear from the fall on 9/29/15 and an abrasion from the fall on 10/24/15 fall. The MDS Coordinator was asked how the MDS should have been coded. The MDS Coordinator stated, "It should be 2 or more falls without injury and 2 or more falls with injury."	F 278		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 280 F 280 SS=G	Continued From page 3 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an 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 and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observations and interview, the facility failed to revise comprehensive care plans to reflect interventions related to weight loss and/or falls for 2 of 21 (Residents #26 and 2) sampled residents included in the stage 2 review. The failure to implement a new and appropriate interventions after each fall resulted in actual harm when Resident #26 fell again sustaining a left hip fracture on 6/29/15. The findings included:	F 280 F 280	02/17/16 The Comprehensive Care Plans for Resident #26 was reviewed and revised to reflect appropriate fall interventions for a cognitively impaired resident on 02/16/2016 by Director of Nursing and MDS Coordinator. The Comprehensive Care Plan for Resident #2 was reviewed and revised with appropriate interventions for weight loss on 02/16/2016 by the Director of Nursing and MDS Coordinator. The Comprehensive Care Plans for all residents with a history or potential for falls and weight loss were reviewed and revised on 02/16/2016 by the Director of Nursing and MDS Coordinator.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445470	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 01/27/2016
NAME OF PROVIDER OR SUPPLIER BENCHMARK HEALTHCARE OF PURYEAR INC		STREET ADDRESS, CITY, STATE, ZIP CODE 220 COLLEGE STREET PURYEAR, TN 38251	

(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 280	Continued From page 4 1. Review of the facility's "Comprehensive Care Plan" policy revealed, "...i. fall interventions documented... after each fall..." Medical record review revealed Resident #26 was admitted 11/24/14 to the facility and readmitted on 7/2/15 with diagnoses of Schizophrenia, Senile Degeneration of Brain, Insomnia, Abnormality of Gait and Mobility, Essential Hypertension, Cataract, Anxiety, Hearing Loss, Muscle Weakness, Hypothyroidism, Major Depressive Disorder, Osteoarthritis, and Dementia with Behavioral Disturbance. The "Psychiatric Progress" notes dated 12/15/14 revealed "...paranoia is worsening... does not give correct date and time... not aware of current events... 2/27/15... does not give correct date and time... not aware of current events... increased delusions... 3/18/15... is always confused... self-care skills are impaired and she depends on others to perform them... not aware of current events... 4/8/15... always confused... does not correctly give current location... date and time..." The Prospective Payment System (PPS) Minimum Data Set (MDS) dated 12/22/14 indicated severe cognitive impairment and required assistance with mobility, toilet use and transfer. The MDS dated 2/23/15 indicated moderately impaired cognitive skills for daily decision making and required assistance with mobility, toilet use and transfer. The revised comprehensive plan dated 12/3/14 documented Resident #26 had a potential for falls and injuries related decrease mobility with interventions that were not updated with fall on	F 280	Nursing staff and CDM were in-serviced on 02/17/2016 by the Director of Nursing on the Comprehensive Care Plan Policy, Fall Investigation Report, Dietary Committee Meeting policy, and At Risk Meeting. At Risk Committee Meeting will be held weekly, beginning 02/19/2016, to ensure all residents with falls and weight loss will be reviewed for appropriateness of interventions. At Risk Meeting will be led by the LNHA or her designee. Fall Investigation Report revised on 02/17/2016 by the Director of Nursing to include most recent BIMS score to ensure interventions are appropriate for cognitively impaired residents who fall. "Strategies to Reduce Falls" was placed in the Resource Manual on 02/17/2016 by the Director of Nursing for staff to refer to. The Facility will conduct a monthly Dietary Committee Meeting led by the Director of Nursing or her designee to identify any residents with weight loss, ensure interventions are appropriate, and care plan is revised to reflect these interventions.	02/17/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 280	Continued From page 5 5/4/15. Interventions for the fall on 3/15/15 was encourage with toileting, the fall on 3/28/15 was resident will call for assistance and the fall on 6/15/15 was the same intervention as on 3/15/15 to encourage with toileting. The care plan was not updated with a intervention for fall on 5/4/15. Interventions for falls on 2/1/15, 3/15/15 and 6/15/15 were not appropriate for Resident #26's severe cognitive impairment. Review the fall risk assessments for Resident #26 dated 1/27/15 through 6/29/15 documented high risk for falls. The "Fall Investigation" reports documented: a. 2/1/15 - "...resident in dining room... resident holding onto rolling walker, staggering... breaks were unlocked. Resident fell in floor landing on left hand... Injury... hematoma to right hand... skin discoloration left hand... Root Cause... attempting to transfer and the brakes were not locked on her rolling walker the walker rolled causing her to fall... Intervention... remind resident to lock the breaks before transferring to prevent walker from rolling causing her to fall..." b. 3/15/15 - "...resident lying on floor... interventions... encourage resident to toilet... Injury... skin discoloration... Root Cause... trying to get to bathroom in hurry... tried to open door and fell... incontinent when staff helped her up... interventions... assist and encourage resident to toilet every two hours and as need..." c. 5/4/15 - "resident up ambulating... heard loud noise and noted resident lying supine in middle of hallway... Root Cause resident ambulating with walker and fell backwards to floor hitting head...	F 280	Any future noncompliance in prompt documentation in the care plans for falls and weight losses with appropriate interventions will be reported to the Quality Assurance/ Improvement Committee by the Director of Nursing, MDS Coordinator, CDM and/or their designees for immediate action to resolve the issue. Amendment to POC 02/17/2016 F280 G – Resident # 26 had 1 fall (04/10/2016) since survey date. New Fall Investigation Report was completed, noting current BIMs score. Fall Risk Assessment updated as well. No Injury occurred from fall. Root Cause identified and new intervention initiated (bed mat alarm while in bed). Care Plan and CNA Kardex updated to reflect new intervention. Fall Investigation Report reviewed by DON, LNHA, and Medical Director.	02/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 280	Continued From page 6 Injury c/o [complained of] pain to lle [left lower extremity] with inability to flex... significant amount of blood from back of head and 2 small skin tears to both elbows... to ER [Emergency Room] no fx [fracture]... Intervention - nwb [no weight bearing] on left side... treatment to head laceration..." There was no intervention documented following this fall. d. 6/15/15 - " ...resident trying to walk to restroom and fell could get her... states that she was trying to go the restroom... Injury skin tear to left elbow... Root Cause resident attempting to walk to restroom and fell before nurse could catch her... Intervention assist resident to toilet every 2 hours and as needed..." e. 6/29/15 - " ...resident fell in floor sitting upright against bedside table attempted to self-transfer from chair to bed... Injury... left hip... taken to hospital... fx left hip... Root Cause resident attempted to self-transfer from chair to bed and fell in the floor... Assessment... probable left hip fx noted... Interventions... body alarm to chair on return to alert staff of attempted transfer attempts..." Review of a radiology report dated 6/29/15 documented "...Fracture left hip..." Observations in the dining room on 1/26/16 at 6:08 PM, revealed Resident #26 sitting in wheelchair eating supper. Slight bruising (quarter size) barely visible over left eye. Confusion noted had to be cued to finish supper meal. Observations on the A hall on 1/27/16 at 9:24 AM, revealed Resident #26 sitting in wheelchair by the medication cart, confusion was noted as the	F 280	Amendment con't Overall Fall Reduction noted throughout community since last survey as follows: February 2016 – 6 falls (none with major injury) March 2016 – 4 falls (none with major Injury) April 2016 – 4 falls (none with major injury) Fall Investigations Reports with updated Fall Risk and BIMs scores completed with each report. New interventions are initiated and appropriate. Report is reviewed by the DON, LNHA, and Medical Director. Weekly Fall Analysis Log completed and reported to At Risk Committee every week to ensure Fall Investigation Reports are completed. Incidents tracked by Monthly Fall Analysis by Quality Assurance/Improvement Committee to ensure facility remains within compliance.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445470	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 01/27/2016
NAME OF PROVIDER OR SUPPLIER BENCHMARK HEALTHCARE OF PURYEAR INC		STREET ADDRESS, CITY, STATE, ZIP CODE 220 COLLEGE STREET PURYEAR, TN 38251	

(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 280	Continued From page 7 nurse talked to the resident. Interview with the Director of Nursing (DON) on 1/27/15 at 10:20 AM, in the conference room, the DON was asked if a risk management committee meeting meets weekly for falls. The DON stated "No." The DON was asked if Resident #26 would remember to call for help. The DON stated, "She is confused. I doubt it." The DON was asked is it was appropriate to repeat the same intervention to assist with toilet every 2 hours for the falls on 3/15/15 and 6/15/15. The DON stated, "No." The DON was asked if "no weight bearing to left side" was an intervention or an order. The DON stated, "No, it was an order." The failure to implement new appropriate interventions after each fall resulted in actual harm when Resident #26 fell again sustaining a left hip fracture on 6/29/15. 2. Review of the facility's "Comprehensive Care Plan" policy revealed, "...viii. Weight loss/gain addressed..." Medical record review revealed Resident #2 was admitted to the facility on 10/18/11 with diagnoses of Alzheimer's disease, Generalized Anxiety Disorder, Brief Psychosis, Major Depressive Disorder, Hypothyroidism, Dementia, and Reflux Disease without Esophagitis. Review of the annual MDS dated 10/4/15 revealed Resident #2 required supervision and encouragement during meals and Resident #2 had no weight loss. Review of quarterly MDS dated 1/14/16 revealed Resident #2 had a weight loss of 5 percent (%) or more in the last month or 10% or more in last 6 months	F 280	Amendment con't Resident #2 continues to have weights every week. Medical record review for Resident #2 was completed by RD on 01/31/2016. RD noted that "currently wt loss positive", resident "tolerating present diet plan with good intakes" and requesting to continue with weekly weights and follow-up RD if weight loss reported (per Health Technologies Inc. Nutritional Care Form). RD was notified on 02/11/2016 by CDM of continued weight loss and recommendations were made for clear house supplement, 1 container, with lunch and supper. All residents weights are monitored by the At Risk Committee each week. Weight Summary reports are reviewed to monitor weight losses on all residents. Notations made to At Risk Minutes to ensure residents with weight loss have appropriate Interventions in place. The RD visited the facility on 01/31/2016, 02/28/2016, and 03/31/2016 to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 280	Continued From page 8 The "Weights" report documented Resident #2 experienced a 6.6 pound weight loss (5% loss) between 10/6/15 and 11/4/15, and a 10 pound weight loss (7% loss) between 12/12/15 and 1/11/16. The care plan dated 7/21/15 was not revised to include new interventions related to the significant weight loss. The care plan meeting note dated 9/23/15 revealed, "...will consult with RD [Registered Dietician] for supplement recommendations..." The facility's "Nutrition Alert Program" policy " documented, "...Residents with a history of weight loss or at nutritional risk as determined by further criteria shall be followed by the Quality Assurance Team... 4. Additional approaches to increase overall calorie intake... RD/LD [Licensed Dietician]..." Telephone interview with the RD, on 1/27/16 at 4:22 PM, in the conference room, the RD stated, "Not been contacted about Resident #2 since May 2015." Interview with the Director of Nursing (DON) on 1/27/16 at 6:39 PM, outside of the Administrator's office, the DON was asked at what point does the RD provide recommendations for a significant weight loss in October [2015]. The DON stated, "The RD was not here in November. She has not been here since September [2015]." The DON was asked if the care plan should have been updated for Resident #2's significant weight loss. The DON stated, "Yes."	F 280	Amendment Con't review medical records of residents, monitor weights and make recommendations if applicable. The Dietary Committee continues to meet monthly to ensure orders are received from RD recommendations and review current diet and supplement reports for accuracy. The Quality Assurance/Improvement Committee review compliance in regards to weight losses monthly.	
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 282 SS=G	Continued From page 9 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 medical record review and interview, the facility failed to follow interventions related to falls or weight loss for 3 of 21 (Residents #24, 6, and 2) sampled residents included in the stage 2 review. The facility failed to ensure a body alarm was attached as care planned which resulted in actual harm when Resident #24 fell while getting out of bed sustaining a fractured nose on 1/25/16. The facility failed to ensure an evaluation was completed for gait training which resulted in actual harm when Resident #6 fell again, sustaining a laceration that required sutures on 9/26/15. The findings included: 1. Medical record review revealed Resident #24 was admitted to the facility on 9/11/15 with diagnoses of Alzheimer's Disease, Anxiety Disorder, Chronic Obstructive Pulmonary Disease, Hypertension, Mood Affective Disorder, Psychotic Disorder, Enlarged Prostate, and Lower Urinary Tract Symptoms. The care plan dated 12/2/15 documented, "...I have potential for falls... Interventions... I wear a body alarm at all times..." Resident #24's a body alarm was not attached on 1/25/16 when he fell getting out of bed.	F 282	Resident #24 Body Alarm was attached by Licensed Staff on 01/27/2016 and in good working order. Body Alarm checks added to resident's MAR to ensure alarm properly working and attached to resident on 02/01/2016 by Director of Nursing. Kardex for Resident #24 was reviewed on 02/17/2016 by Director of Nursing to Ensure all nursing staff were aware of order for this resident's Body Alarm and to ensure they check Body Alarm for proper placement and working condition. Order was obtained on 01/28/2016 for PT and OT to evaluate and treat Resident #6. Therapy orders were obtained for PT for 3 times weekly on 02/03/2016 and for OT for 3 times weekly on 02/02/2016. Resident #6 continues to be on case load at present.	02/01/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 282	Continued From page 10 A fall investigation report dated 1/25/16 documented, "...Fall... Patient started yelling for help... CNA called me into room... Observed patient lying on the floor face down in pool of blood... EMS [Emergency Medical Services] was called... patient was transferred to Hospital... ROOT CAUSE... Resident fell out of bed resident's alarm was not attached to resident at time of fall so staff did not hear an alarm that would have alerted them that he was trying to get up... INTERVENTIONS... Resident was sent to the hospital for evaluation and treatment... Staff to be in-serviced about following care guides/care plans..." A hospital report dated 1/25/16 documented, "...Impression... Remote appearing left nasal bone and nasal process fractures..." Interview with the Director of Nursing (DON) on 1/26/16 at 2:55 PM, in the DON's office, the DON was asked about Resident #24's fall on 1/25/16. The DON stated, "He fell out of bed and his alarm was not attached." The DON was asked if you would expect the alarm to be attached to the bed. The DON stated, "Yes." The facility failed to ensure a body alarm was attached as care planned which resulted in actual harm when Resident #24 fell while getting out of bed sustaining a fractured nose on 1/25/16. 2. Medical record review revealed Resident #6 was admitted to the facility on 7/9/14 with Dementia with Behavioral Disturbance, Anxiety, Depression, Alzheimer's Disease, Abnormalities of Gait and Mobility, Muscle Weakness, Hypothyroidism, Hypertension, and	F 282	All residents with current physician's order for a Body Alarm were checked by Director of Nursing on 02/01/2016 to ensure all were attached to the resident and tested for proper functioning (magnet released to ensure alarm would sound). All residents with current physician's order for Body Alarms had Body Alarm Checks added to their MAR on 02/01/2016 by the Director of Nursing. All residents were reviewed by Therapy Director and Director of Nursing on 02/16/2016 to ensure none were in need of referral for services. No new referrals were added to Therapy case load. Nursing staff in-serviced on policy and procedure on Therapy Screening and "Request for Therapy Evaluation" form and appropriate documentation of Body Alarm Checks by the Director of Nursing on 02/17/2016.	021716

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 282	Continued From page 11 Arteriosclerotic Heart Disease. The care plan dated 12/2/14 and continued to present documented, "...problem... risk for falls/injuries related to gait/balance problems... interventions... help to negotiate barriers in the lounge/hallway so that I may ambulate safely... provide diversions when resident is walking in hallways going door to door to help prevent falls... OT [Occupational Therapy] to evaluate and implement a treatment plan..." The facility was unable to provide documentation the OT had completed an evaluation or implement a treatment plan for Resident #6 as documented in the care plan. Interview with the OT on 1/27/16 at 5:46 PM, in the rehabilitation office, the OT was asked about Resident #6 falling on 4/22/15 and the intervention for therapy to evaluate Resident #6 for gait imbalance. The OT stated, "No, I don't have a report." Interview with the Administrator on 1/27/16 at 6:32 PM, in the Administrator's office, the Administrator was asked who does the evaluations on residents who fall. The Administrator stated, "The OT is our Rehabilitation Director." The Administrator was asked if therapy evaluations should be documented. The Administrator stated, "Yes." The facility failed to ensure an OT evaluation was completed after the 4/22/15 fall, as care planned. The failure to complete the evaluation resulted in actual harm when Resident #6 fell again on 9/26/15, sustaining a laceration that required sutures.	F 282	Any future noncompliance with placing Body Alarms on correctly, Body Alarms Not in working condition, or not notifying the Therapy Director timely on referrals to screen will be reported to the Quality Assurance/Improvement Committee by the Director of Nursing, MDS Coordinator, or their designee for immediate action to resolve. Amendment to POC 02/17/2016 F282 G – Resident # 24 continues to wear a body alarm at all times. Body alarm is check every 2 hours by nursing staff to ensure proper functioning. Battery to body alarm is changed every month. The above is documented by licensed staff on the resident's Medication Administration Record.	02/17/16

Amendment to POC 02/17/2016 continued :
F 282 G-

Resident #6 was initially evaluated by Therapy Supervisor on 01/28/2016 and orders obtained for OT on 02/02/2016 and PT on 02/03/2016 for each discipline 3 times per week. Orders received on 03/02/2016 and 03/04/2016 for re-certification of therapies 3 times per week for 4 weeks and again on 04/01/2016 and 04/03/2016 for an additional 4 weeks. Therapy Progress notes reveal Resident #6's current level of functioning to be as follows:

OT (04/25/2016) –

1. Patient actively participates in 32 minutes of graded therapeutic activities
2. Patient is able to complete all bathing tasks requiring minimal assistance
3. Patient demonstrates standing balance of G-/F+ dynamic and maintain for 23 minutes requiring modified independence with 25% verbal instruction/cues
4. Patient is all to safely persom functional transfers requiring supervision with 25% verbal instruction/cues

PT (04/25/2016)

1. Patient is able to safely transition from supine <> sitting position requiring modified independence
2. Patient requires rolling walker and supervision for safe ambulation for 250 feet
3. Patient demonstrates B LE muscle strength of 4/5 good
4. Patient is able to safely transfer from <> wheelchair requiring supervision.

Resident is expected to complete ordered therapy on 04/29/2016.
Current mobility orders per POS for April 2016 – Up ad lib with wheeled walker/may use wheelchair if needed.

Resident #2 had medical record reviewed by RD on 01/31/2016. RD made notation in Resident #2's record stating "noted wts within desirable wt limits", "is receiving yogurt at breakfast", and "no diet change at this time even with noted wt loss—per CDM is considered positive". Resident #2 continues on weekly weights and follow-up with RD noted on 02/14/2016 due to continued weight loss with recommendations received for clear house supplement with lunch and supper tray. Orders received from Medical Director.

Staff continue to document on MAR, all residents with body alarms. Staff check body alarms every shift to ensure the alarm is in proper working function and attached to resident. Batteries are changed in all body alarms every month as needed and documented on the MARs

Any resident with a fall reported since last survey has received a Therapy Screen by the Therapy Supervisor. Nursing staff complete a Request for Therapy Screen form and forward to the Therapy Supervisor. Therapist then completes a screening form to determine if the resident is appropriate for therapy services. Information is then sent to the At Risk Committee to ensure compliance of the above.

Weights and therapy screens are monitored by the At Risk Committee meetings every week with information provided to the Quality Improvement/Performance Committee which met on 02/26/2016, 03/23/2016, and 04/14/2016. Therapy evaluations have resulted in several residents being appropriate for therapy services and added to caseload. RD has visited on 01/31/2016, 02/28/2016, and 03/31/2016 with recommendations made for several residents. Medical Director was notified and orders received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 282	Continued From page 12 3. Medical record review revealed Resident #2 was admitted to the facility on 10/18/11 with a readmission date of 1/11/16 with diagnoses of Alzheimer's Disease, Depression, Anxiety, Hypothyroidism, Dementia, Chronic Venous Insufficiency, Reflux Disease and Chronic Obstructive Pulmonary Disease. The annual Minimum Data Set (MDS) dated 10/4/15 documented Resident #2 needed supervision oversight and encouragement during meals, had no swallowing disorder and no weight loss. The quarterly MDS dated 1/14/16 revealed Resident #2 needed supervision, oversight and encouragement during meals, no swallowing issues, did have a weight loss of 5 percent (%) or more in the last month or 10% or more in last 6 months. The care plan dated 10/16/12 documented, "...Nutritional Evaluation quarterly. Date initiated 10/16/14..." The care plan meeting note dated 9/23/15 documented, "...care plan meeting held this day with residents POA [power of attorney]... will consult with RD [Registered Dietician] for supplemental recommendations..." The facility was unable to provide quarterly nutritional assessments for 2015, as care planned. Telephone interview with the Registered Dietician (RD) on 1/27/16 at 4:30 PM, in the conference room, the RD was asked about Resident #2 and	F 282		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 282	Continued From page 13 the weight loss. The RD stated, "Have not been contacted about Resident #2 since May 2015."	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, the facility failed to ensure a transdermal patch was administered correctly when Licensed Practical Nurse (LPN) #1 failed to clean the application site for 1 of 1 (Resident #3) resident observed receiving a transdermal patch during medication administration. The findings included: The facility's "Topical Medications" policy documented, " ...30. Clean the skin... e. Trans-dermal patches i. apply to clean... area..." Medical record review for Resident #3 revealed an admission date of 12/23/15 with diagnoses of Embolism and Thrombosis of Arteries of the Lower Extremities, Peripheral Vascular Disease, Urinary Tract Infection, Bronchopneumonia, Cellulitis, Edema, Major Depressive Disorder.	F 309	Licensed Practical Nurse #1 who applied transdermal patch to Resident #3 was in-serviced on Topical Medication policy 02/01/2016 by Director of Nursing. Licensed Practical Nurse #1 had Medication Administration Observation completed for administration of transdermal patch on 02/04/2016 by the Director of Nursing. Roster of all residents with transdermal patches obtained. Licensed Practical Nurse #1 had Medication Administration Observation completed on 02/02/2016 by the Director of Nursing to ensure Topical Medication policy and administration of transdermal patches was followed on all residents with transdermal patches ordered.	021716

Benchmark Healthcare of Puryear, Inc.
Recertification Survey
CMS Certification #: 44-5470

F309 continued:

All Nursing Staff was in-serviced on Topical Medication policy on 02/17/2016 by the Director of Nursing.

The Director of Nursing and/or MDS Coordinator will perform Medication Administration Observations, with special attention to topical medications, and complete audit as documentation one (1) time a week for four (4) weeks and then monthly ongoing as part of the facility QA.

The Director of Nursing and/or her designee will monitor corrective action through review of Medication Administration Observations and documentation of audits and any issues or concerns noted will be reported to the Administrator and corrected immediately.

The Administrator or her designee will monitor corrective action through review of Medication Administration observation/audits weekly for four (4) weeks and then monthly ongoing.

The Director of Nursing and/or her designee will also report the results of Medication Administration observations/audit documentation and any concerns noted during the Medication Administration observation/audits during the facility monthly QA meeting.

Errors in any Medication Administration Observation will be followed by the Quality Assurance/Improvement Committee to ensure nursing staff are following correct procedures and re-educated if necessary. Any future noncompliance with correct application of transdermal patches will be reported to the Quality Assurance/Improvement Committee by the Director of Nursing, MDS Coordinator and/or their designee for immediate action to resolve.

Completion Date: 02/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 14 Review of the Physician's orders dated 1/26/16 documented FentaNYL [Fentanyl] Patch 72 hour 25 mcg [microgram] / [per] HR [hour] apply 1 patch transdermal every day shift every 3 day(s) for pain..." Observations on 1/26/16 at 12:30 PM, at the nurses station, LPN #1 removed the Fentanyl patch from Resident #3's left chest and applied a Fentanyl patch to Resident's right chest. LPN #1 did not clean the area after removing the old patch or clean the area prior to applying the new patch. Interview with LPN #1 on 1/27/16 at 9:28 AM, at the nurses station, LPN #1 was asked should an area be cleaned before a patch is applied. LPN #1 stated, "Yes, so it [transdermal patch] will adhere it [area of application] should be cleaned." Interview with the Director of Nursing (DON) on 1/27/16 at 9:35 AM, at the nurses' station, the DON was asked would you expect the nurse to clean the skin before a Fentanyl patch is applied to the skin. The DON stated, "Yes, I would."	F 309		
F 323 SS=H	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	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 323	Continued From page 15 by: Based on policy review, medical record review, review of incident reports, review of fall investigation reports, observation and interview, the facility failed to follow the facility's fall prevention policy related to implementing appropriate interventions after a fall, updating the care plan for a fall and review resident falls during the weekly risk management committee meetings for 3 of 7 (Residents #6, 24, and 26) sampled residents reviewed with falls. The facility failed to ensure a body alarm was attached as care planned which resulted in actual harm when Resident #24 fell while getting out of bed sustaining a fractured nose on 1/25/16. The failure to implement a new intervention after each fall resulted in actual harm when Resident #26 fell again sustaining a left hip fracture on 6/29/15. The facility failed to ensure an evaluation was completed for gait training which resulted in actual harm when Resident #6 fell again, sustaining a laceration that required sutures on 9/26/15. This resulted in Substandard Quality of Care. An extended survey was completed on 1/27/16. The findings included: 1. Medical record review revealed Resident #24 was admitted to the facility on 9/11/15 with diagnoses of Chronic Obstructive Pulmonary Disease, Alzheimer's Disease, Anxiety, Hypertension, Psychotic Disorder with Delusions, Cardiac Pacemaker, Muscle Weakness, Depression, Dementia, and Arteriosclerotic Heart Disease.	F 323	Body Alarm for Resident #24 was checked for proper functioning and and placement on 01/27/201 by the Director of Nursing. Documentation for ensuring staff check correct Body Alarm placement and functioning added to MAR on 02/01/2016 by the Director of Nursing. Care Plan for Resident #26 reviewed and revised on 02/16/2016 by the Director of Nursing and MDS Coordinator for appropriate fall interventions based on her most recent BIMS score of 4 on 12/04/2016 completed by Social Service Director. Therapy Director completed an evaluation on Resident #6 on on 01/28/2016 and orders received for OT 3 times weekly on 02/02/2016 and PT 3 times weekly on 02/03/2016.	021016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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
				02/17/16
F 323	Continued From page 16 The admission Minimum Data Set (MDS) dated 9/24/15 documented a Brief Interview for Mental Status (BIMS) of 3, indicating severe cognitive impairment and a history of falls in the last the last 6 months prior to admission. The quarterly MDS dated 12/24/15 documented a BIMS of 2, indicating severe cognitive impairment, and 2 falls since the admission MDS was completed. The care plan dated 12/2/15 documented, "...I have potential for falls... Interventions... I wear a body alarm at all times..." During the period of 9/12/15 to 1/25/16 there were 13 assessments that documented Resident #24 was high risk for falls. Fall investigation reports documented the following: a. 9/15/15 - "...Fall... Resident was found on the floor in front of his chair... ROOT CAUSE... Nurse was assisting CNA's [Certified Nursing Assistants] when alarm sounded... when they reached the area... resident was in [on] the floor... INTERVENTIONS... Respond to alarm in a timely manner..." b. 9/29/15 - "...Fall... Resident's body alarm was going off and CNA went to check on resident... resident was lying in [on] the floor... Skin tear... right knee... Resident apparently climbed out from the foot of the bed... ROOT CAUSE... Alarm sounded... staff went into resident's room... found him in [on] the floor at the foot of his bed... Resident climbed out of the foot of his bed and fell on the floor causing a skin tear to his knee... INTERVENTIONS... MD [Medical Doctor]... notified... Keep resident close to nurses station	F 323	All residents with Body Alarms were checked for proper functioning and placement on 02/01/2016 by the Director of Nursing. All residents with orders for Body Alarms had a Body Alarm Check added to their MARs on 02/01/2016 by the Director of Nursing. Any resident with faulty or non-functioning alarms were replaced. All residents will care plans that include potential or history of falls were reviewed for appropriate fall interventions by the Director of Nursing and MDS Coordinator on 02/16/2016. Therapy Director and Director of Nursing reviewed all residents currently residing at the facility on 02/16/2016 for need of therapy screening/referral. None identified. At Risk Committee Meeting will be held on 02/19/2016 and weekly thereafter, to ensure all residents have appropriate interventions after any fall.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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
				021716
F 323	Continued From page 17 while awake... check on resident often while in bed sleeping..." c. 10/1/15 - "...Fall... Resident was sitting in the hallway in broda chair [chair that will tilt and recline]... Nurse heard alarm sound... Nurse observed resident attempt to stand up before she could respond. Resident sat on floor on buttocks in front of wc [wheelchair]... INTERVENTIONS... MD notified... ensure... needs are being met [toileting, hunger, thirst, pain]... then provide activities to keep resident's mind off of standing up..." d. 10/7/15 - "...Fall... Resident was sitting in broda chair in hallway... Nurse and cna observed resident roll out to side of chair and fall in [on] floor onto R [right] side before staff able to respond... ROOT CAUSE... Resident rolled over the side of his broda chair, causing him to fall on the floor. resident was stating he was wanting to go home... INTERVENTIONS... MD notified... Call wife if resident becomes too restless... see if she will come sit with him..." e. 10/24/15 - "...Fall... Residents body alarm sounding... Went to residents room and found resident sitting in [on] the floor on mat next to bed... ROOT CAUSE Alarm sounded... staff found resident sitting in [on] floor in his room... He had attempted to get out of bed and cannot walk without assistance... INTERVENTIONS... Assessment... Tx [treatment]... to abrasion... MD... notified..." f. 11/9/15 - "...Fall... CNA called nurse to room... Pt [patient] observed sitting in [on] the floor next to his bed... transferred to wheelchair... MD and DON [Director of Nursing] made aware... ROOT	F 323	Nursing staff was in-serviced on correct documentation for residents with Body Alarms. Nursing staff in-serviced on revised Fall Investigation Report which included most recent BIMS score to ensure interventions are appropriate for cognitively impaired residents who fall. "Strategies to Reduce Falls" was placed in Resource Manual for staff to refer to on 02/17/2016 by the Director of Nursing. New body alarms and other fall prevention equipment, such as fall mats, alarming fall mat, bed sensor alarms, chair sensor alarms, anti-roll bolsters, etc., were ordered from Medline on 02/04/2016 by the Director of Nursing. New supplies placed in supply room on shelving labeled "Fall Prevention Supplies". Staff in-serviced on location of new supplies and new inventory and all of the above Director of Nursing on 02/17/2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 323	Continued From page 18 CAUSE... yelling in his bed for his wife... found on floor... Alarm did not sound... resident had unclipped it from his clothes... became combative... Interventions... MD... notified... Resident was sent out to [named facility] for continuous behavior issues..." g. 12/11/15 - "...Staff heard resident's body alarm and responded to room... Resident... sitting on side of bed... staff assisted to floor on mat when began slipping off bed... ROOT CAUSE... Resident sitting on side of bed... doesn't have much muscle strength area or legs... began to slide of the bed... alarm sounded... staff came... lowered him to fall mat... INTERVENTIONS... MD... notified... Get resident out of bed if awake longer than 10- [to] 20 minutes..." h. 12/16/15 - "...Fall... Staff heard resident alarm sound... staff responded... found sitting on buttocks on floor mat in front of bed... stated he was trying to go to pee... md... don [director of nursing] aware... INTERVENTIONS... MD... notified... Toilet resident before and after meals... PRN [as needed]..." i. 12/18/15 - "...Fall... Resident was in bed after breakfast... Staff heard resident yelling help... Staff found resident sitting on floor next to bed on buttocks... Resident noted to be wet and soiled... md don... aware... Resident to be assisted to restroom before bed... ROOT CAUSE... Resident was wet and soiled... INTERVENTIONS... MD... notified..." j. 12/30/15 - "...Fall... nurse was alerted to the fall by CNA taking care of resident... patient was lying on his right side in the floor next to the blue mat beside the bed... right elbow bleeding... Elbow	F 323	Any future noncompliance with in prompt and appropriate fall prevention/interventions will be reported to the Quality Assurance/Improvement Committee by the Director of Nursing, Therapy Director, and/or their designee for immediate action to resolve the issue. Amendment to POC 02/17/2016 F323 H – Resident #24 and Resident #26 continue to have a body alarm. Both are in proper working condition and such is documented on the resident's Medication Administration Record every shift. Batteries in alarms have been changed every month and as needed and documented on the MAR as well. The Care Plans for Resident #24 and Resident #26 also reflect the use of body alarms for these residents.	02/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445470	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 01/27/2016
NAME OF PROVIDER OR SUPPLIER BENCHMARK HEALTHCARE OF PURYEAR INC		STREET ADDRESS, CITY, STATE, ZIP CODE 220 COLLEGE STREET PURYEAR, TN 38251	

(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 323	Continued From page 19 has... 2.4in [inch] x [by] 3. 6in [inch] area where the skin skin had peeled off... bleeding... Resident stated he wanted to get up... ROOT CAUSE... Upon awaking... resident immediately tried to get up, knocking his wedge that keeps him in the middle of the bed onto the floor as he fell... INTERVENTIONS... MD... notified... Staff to get resident up between 5 & [and] 6 AM if he slept most of... night to prevent him from trying to get up himself..." k. 1/25/16 - "...Fall... Patient started yelling for help... CNA called me into room... Observed patient lying on the floor face down in pool of blood... EMS [Emergency Medical Services] was called... patient was transferred to Hospital... ROOT CAUSE... Resident fell out of bed resident's alarm was not attached to resident at time of fall so staff did not hear an alarm that would have alerted them that he was trying to get up... INTERVENTIONS... Resident was sent to the hospital for evaluation and treatment... Staff to be in-serviced about following care guides/care plans..." A hospital report dated 1/25/16 documented, "...Impression... Remote appearing left nasal bone and nasal process fractures..." Interview with the DON on 1/26/16 at 2:55 PM, in the DON's office, the DON was asked about Resident #24's fall on 1/25/16. The DON stated, "He was sent to the hospital. He fell out of bed. His alarm was not attached." The DON was asked if she would expect the alarm to be attached to the bed when Resident #24 was in bed. The DON stated, "Yes, I do not know who did not attach it." The DON was asked if Resident #24 was injured after the fall. The DON stated,	F 323	Amendment Con't Resident #6 was evaluated by Therapy Supervisor and orders obtained for OT and PT (see previous amendment to F282 – for Resident #6 current status). Since most recent survey, the facility ordered new Fall Prevention Equipment on 02/04/2016 and has made an additional order for body alarms and sensor floor mats from Horizon Healthcare Supply on 4/20/2016 to ensure the facility has adequate quantities for use and on-hand, in the event equipment is needed in the future. Therapy Supervisor continues to screen all resident with a reported fall and placing residents on caseload that are found to be appropriate for therapy services.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445470	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 01/27/2016
NAME OF PROVIDER OR SUPPLIER BENCHMARK HEALTHCARE OF PURYEAR INC		STREET ADDRESS, CITY, STATE, ZIP CODE 220 COLLEGE STREET PURYEAR, TN 38251	

(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 323	Continued From page 20 "Apparently he fractured his nose." Interview with the DON on 1/26/16 at 5:20 PM, in the hall outside the Administrator's office, the DON was asked where the CNAs would document the body alarm. The DON stated, "They do not document." The DON was asked if she knew who had taken care of Resident #24 the night he fell. The DON stated, "I haven't found out, yet." Interview with CNA #2 on 1/27/16 at 8:00 AM, in the conference room, CNA #2 was asked if she worked the night shift on 1/25/16 when Resident #24 fell. CNA #2 stated, "I worked 10 PM to 6 AM. I was working by myself that night. We were one short. Then I heard him [Resident #24] calling out, he was laying in [on] the floor. There was blood. The alarm never sounded. More than likely it was not attached. I was here working by myself and taking care of 30 people." CNA #2 was asked how often are alarms checked and if the alarm was checked on the 2:00 rounds. CNA #2 stated, "I didn't check." CNA #2 was asked if there is documentation of alarms being checked every 2 hours. CNA #2 stated, "No, half the time they don't work. They have tape on the back where the cover is missing and the batteries will come out." Interview with the DON on 1/27/16 at 8:45 AM, in the DON's office, the DON was asked, who does the scheduling. The DON stated, "I do." The DON was asked who is responsible for getting someone to work if someone calls in. The DON stated, "I have told them to work on it themselves. If have a lot going on, I'll do it." The DON was asked where a copy of the December, 2015 working schedule was located. The DON stated, "I don't keep those. I don't have it." The DON was	F 323	Amendment Con't The facility has noted an overall reduction in falls as stated in Amended POC for F280. The Quality Assurance/Improvement Committee monitored the overall number of falls on 02/26/2016, 03/23/2016, and 04/14/2016. No falls with noted with major injuries. Medical Director reviewing all falls and ensuring interventions are appropriate by signed the Fall Investigation Reports.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 323	Continued From page 21 asked what she did about the call in for the night of 1/24/16 going into 1/25/16. The DON stated, "I don't know if the CNAs took the call or if they know how to do it. CNA #3 has been having a lot of car trouble, so she hasn't been able to come in for awhile." The DON pointed to the master schedule where CNA #3 had been marked off on 8 previous shifts for January, 2016. The DON was asked if CNA #3 had called her the 24th [1/24/16]. The DON stated, "No, I assume she was going to call in because I tried to get CNA #1 to work. The DON was asked if she was referring to CNA #1 who has an expired certification. The DON stated, "Yes." The DON was asked if she has talked with Licensed Practical Nurse (LPN) #2 about that night. The DON stated, "I haven't asked her about it." Interview with the DON on 1/27/16 at 9:45 AM, in the business office, the DON was asked if there was any documentation of alarms being checked. The DON stated, "No." Telephone interview with LPN #2 on 1/27/16 at 10:10 AM, LPN #2 was asked about the night Resident #24 fell. LPN #2 stated, "That night was so hectic." LPN #2 was asked if the bed alarm was on. LPN #2 stated, "I didn't remember if he did or did not have an alarm." Interview with the Administrator on 1/27/16 at 2:25 PM, in the conference room, the Administrator was asked if she was aware that the night shift staff had been working short handed throughout December, 2015 and January, 2016 due to CNA #3 having car trouble. The Administrator stated, "That particular subject has come up in the last two weeks with the DON... she would be expected to come in." The	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 323	Continued From page 22 Administrator was asked if she was aware that some of the clip alarms [an alarm that will alert staff if a resident gets up] were taped with bandage tape to keep the battery covers on or to take the place of the battery covers. The Administrator stated, "That's news to me." The Administrator was asked where the CNAs document what they do for residents and their rounds and alarm checks. The Administrator stated, "At one time we had it on the MARs [Medication Administration Records]. The DON said no to that so we took it off. It needs to be somewhere where they can document it." The facility failed to ensure the fall intervention of a body alarm was in place as care planned which resulted in actual harm when Resident #24 fell while getting out of bed sustaining a fractured nose on 1/25/16. 2. Medical record review revealed Resident #26 was admitted 11/24/14 to the facility and readmitted on 7/2/15 with diagnoses of Senile Degeneration of Brain, Hearing Loss, Schizophrenia, Insomnia, Abnormality of Gait and Mobility, Essential Hypertension, Cataract, Anxiety, Major Depressive Disorder, Hypothyroidism, Osteoarthritis, Muscle Weakness and Dementia with Behavioral Disturbance. The "Psychiatric Progress" notes dated 12/15/14 revealed "...paranoia is worsening... does not give correct date and time... not aware of current events... 2/27/15... does not give correct date and time... not aware of current events... increased delusions... 3/18/15... is always confused... self-care skills are impaired and she depends on others to perform them... not aware of current	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 323	Continued From page 23 events... 4/8/15... always confused... does not correctly give current location... date and time..." The Prospective Payment System (PPS) MDS dated 12/22/14 indicated severe cognitive impairment and required assistance with mobility, toilet use and transfer. The MDS dated 2/23/15 indicated moderately impaired cognitive skills for daily decision making and required assistance with mobility, toilet use and transfer. The revised comprehensive plan dated 12/3/14 documented Resident #26 had a potential for falls and injuries related decrease mobility with interventions that were not updated with fall on 5/4/15. Interventions for the fall on 3/15/15 was encourage with toileting, the fall on 3/28/15 was resident will call for assistance and the fall on 6/15/15 was the same intervention as on 3/15/15 to encourage with toileting. The care plan was not updated with a intervention for fall on 5/4/15. Interventions for falls on 2/1/15, 3/15/15 and 6/15/15 were not appropriate for Resident #26's severe cognitive impairment. Review the fall risk assessments for Resident #26 dated 1/27/15 through 6/29/15 documented high risk for falls. Review of the "Fall Investigation" reports documented Resident #26 sustained ten falls from 12/31/14 through 1/4/16. The "Fall Investigation" reports documented: a. 12/31/14 - "...Resident loss balance slid to floor... Root Cause... walking fast and lost her balance causing her to fall... Interventions... encourage resident to take her time when	F 323		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 323	Continued From page 24 ambulating with rolling walker..." b. 1/27/15 - "...resident observed lying supine in floor next to dining room chair... trying to sit down with my coffee and lost my footing... root cause got her coffee and carried it back to her seat... was not using her walker... Interventions... encourage resident to ask and allow staff to prepare drinks..." c. 2/1/15 - "...resident in dining room... resident holding onto rolling walker, staggering... breaks were unlocked. Resident fell in floor landing on left hand... Injury... hematoma to right hand... skin discoloration left hand... Root Cause... attempting to transfer and the brakes were not locked on her rolling walker the walker rolled causing her to fall... Intervention... remind resident to lock the breaks before transferring to prevent walker from rolling causing her to fall..." d. 3/15/15 - "...resident lying on floor... interventions... encourage resident to toilet... Injury... skin discoloration... Root Cause... trying to get to bathroom in hurry... tried to open door and fell... incontinent when staff helped her up... interventions... assist and encourage resident to toilet every two hours and as need..." e. 3/28/15 - "...resident attempting to walk to bathroom and tripped over walker wheel... Interventions resident to call for assistance... Injury none... root cause resident attempting to walk to bathroom and tripped over walker wheel... Interventions resident to call for assistance..." f. 4/28/15 - " ...resident reached for walker and began to fall backwards... hit head on floor... Injury small red area to back of head... skin tear	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 323	Continued From page 25 to right elbow... abrasion to left knee bruising to left knee... Root Cause... in dining room and her walker was about 5 feet away... Interventions... to keep walker close by and assist her to and from dining room..." g. 5/4/15 - "resident up ambulating... heard loud noise and noted resident lying supine in middle of hallway... Root Cause resident ambulating with walker and fell backwards to floor hitting head... Injury c/o [complained of] pain to lle [left lower extremity] with inability to flex... significant amount of blood from back of head and 2 small skin tears to both elbows... to ER [Emergency Room] no fx [fracture]... Intervention - nwb [no weight bearing] on left side... treatment to head laceration..." There was no intervention documented following this fall. h. 6/15/15 - "...resident trying to walk to restroom and fell could get her... states that she was trying to go the restroom... Injury skin tear to left elbow... Root Cause resident attempting to walk to restroom and fell before nurse could catch her... Intervention assist resident to toilet every 2 hours and as needed..." i. 6/29/15 - "...resident fell in floor sitting upright against bedside table attempted to self-transfer from chair to bed... Injury... left hip... taken to hospital... fx left hip... Root Cause resident attempted to self-transfer from chair to bed and fell in the floor... Assessment... probable left hip fx noted... Interventions... body alarm to chair on return to alert staff of attempted transfer attempts..." The radiology report dated 6/29/15 documented "...Fracture left hip..." j. 1/4/16 - "....resident was sitting in w/c	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 323	Continued From page 26 [wheelchair] in lounge... find resident lying on r [right] side on floor... observed a quarter size hematoma with swelling noted to R [right] temple... sent to ER... Root Cause... Resident fell asleep in her chair and fell on the floor... Interventions... Staff to put resident in bed if asleep in chair..." Observations in the dining room on 1/26/16 at 6:08 PM, revealed Resident #26 sitting in wheelchair eating supper. Slight bruising (quarter size) barely visible over left eye. Confusion noted had to be cued to finish supper meal. Observations on the A hall on 1/27/16 at 9:24 AM, revealed Resident #26 sitting in wheelchair by the medication cart, confusion was noted as the nurse talked to the resident. Interview with the DON on 1/27/15 at 10:20 AM, in the conference room, the DON was asked if a risk management committee meeting meets weekly for falls. The DON stated "No." The DON was asked if Resident #26 would remember to call for help. The DON stated, "She is confused. I doubt it." The DON was asked is it was appropriate to repeat the same intervention to assist with toilet every 2 hours for the falls on 3/15/15 and 6/15/15. The DON stated, "No." The DON was asked if "no weight bearing to left side was an intervention or an order. The DON stated, "No, it was an order." The failure to implement a new intervention after each fall resulted in actual harm when Resident #26 fell again sustaining a left hip fracture. 3. Medical record review revealed Resident #6 was admitted to the facility on 7/9/14 with	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 323	Continued From page 27 Dementia with Behavioral Disturbance, Anxiety, Depression, Alzheimer's Disease, Abnormalities of Gait and Mobility, Arteriosclerotic Heart Disease, Muscle Weakness, Hypothyroidism, and Hypertension. The annual MDS dated 12/9/15 documented a BIMS of 3, indicating severe cognitive impairment, required supervision for transfers and eating, required one person limited assistance for toileting, was totally dependent on staff for personal hygiene, balance was not steady during transitions and walking, and used a walker. The care plan dated 12/2/14 and continued to present documented, "...I am at risk for falls/injuries r/t [related to] gait/balance problems... interventions... help to negotiate barriers in the lounge/hallway so that I may ambulate safely... provide diversions when resident is walking in hallways going door to door to help prevent falls... OT [Occupational Therapy] to evaluate and implement a treatment plan..." During the period of 3/2/15 to 1/26/16 there were 11 assessments documenting that Resident #6 was a high risk for falls. The fall investigation reports documented the following: a. 4/22/15 - "...Fall... Resident up walking down hallway near front bathrooms and fell to floor, unknown if feet got tangled in walker... Resident assessed... very difficult to arouse... this nurse having to do strong sternal rub... resident sent to ER [emergency room] for evaluation... Staff Statement... I think she got caught up on her	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 323	Continued From page 28 feet... I don't know I seen her fall... Staff Statement...I don't know if she tripped or what I just seen her go down... ROOT CAUSE... walking with walker and her feet got tangled up in the walker causing her to fall... INTERVENTIONS... PT [physical therapy] to eval [evaluate] for gait imbalance..." b. 9/21/15 - "...Fall... Resident was ambulating out of the lounge... lost balance... fell... ROOT CAUSE... Resident... ambulating with walker out of the lounge... lost her balance... fell against the recliner... landed on the floor... INTERVENTIONS... MD [Medical Doctor] notified... Help resident negotiate barriers in lounge so she may ambulate safely..." c. 9/26/15 - "...Fall... resident was on the floor lying on her stomach... another resident was beside her flipped back in her wheelchair... Bleeding noted... resident's right eye had a laceration above it... ROOT CAUSE... it appears as though this resident was about to fall and tried to catch herself or break her fall with other resident's w/c [wheelchair]... INTERVENTIONS... resident bleeding from a laceration above right eye... Sent out by EMS [emergency management services] for evaluation and treatment... MD notified..." Observations in the common area on 1/27/16 at 2:00 PM, revealed Resident #6 stood up from her chair, used her walker, walked several feet to stand in front of another resident, then returned to the chair and sat back down without staff assistance. Observations in the common area on 1/27/16 at 2:15 PM, revealed Resident #6 stood up from her	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 323	Continued From page 29 chair, used her walker, walked out of the common area, down the hallway, and into the dining room without staff assistance. Interview with the OT on 1/27/16 at 5:46 PM, in the rehabilitation office, the OT was asked about Resident #6 falling on 4/22/15 and the intervention for therapy to evaluate Resident #6 for gait imbalance. The OT stated, "No, I don't have a report." Interview with the Administrator on 1/27/16 at 6:32 PM, in the Administrator's office, the Administrator was asked who does the evaluations on residents who fall. The Administrator stated, "The OT is our Rehabilitation Director. He does." The Administrator was asked if therapy screenings should be documented. The Administrator stated, "Yes." The facility failed to ensure an OT evaluation was completed after the 4/22/15 fall, as planned. The failure to complete the evaluation resulted in actual harm when Resident #6 fell again on 9/26/15, sustaining a laceration that required sutures.	F 323		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on review of the Geriatric Medication Handbook, medical record review, observations	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 333	Continued From page 30 and interview, the facility failed to ensure a resident was free of a significant medication error when 1 of 2 nurses (Licensed Practical Nurse (LPN) #1) failed to administer insulin within the proper time frame related to meals for Resident #4, who received an insulin injection. The findings included: Review of the Geriatric Medication Handbook, eleventh edition, page 41 documented, "DIABETES: INJECTABLE MEDICATIONS... novolog... rapid-acting insulin Analog... ONSET... 15 min [minutes]... TYPICAL ADMINISTRATION / COMMENTS 5- [to] 10 minutes before meals..." Medical record review for Resident #4 documented an admission date of 9/10/15 with diagnoses of Type 2 Diabetes Mellitus. Review of the physician's orders dated 8/6/15 revealed, " ...novoLOG [Novolog] 100 UNIT / [per] ML [milliliters]... inject as per sliding scale... 181- [to] 220 [blood sugar reading] = [amount of insulin to be administered] 4 [units]... subcutaneously before meals and at bedtime..." Observation on 1/25/16 at 12:20 PM, in the shower room, LPN #1 administered 4 units of Novolog insulin to Resident #4. Resident #4 did not receive a lunch tray or a substantial snack until 12:44 PM. Resident #4 did not start eating until 12:47 PM, 27 minutes after the Novolog insulin was administered and before Resident #4 took the first bite of food. Interview with LPN #1 on 1/26/16 at 3:45 PM, in conference room, LPN #1 was asked how long after Novolog insulin was administered should a resident receive a meal or a substantial snack.	F 333	LPN #1 was In-serviced on Novolog Insulin and policy regarding fast acting insulins on 01/28/2016 by the Director of Nursing. Medication Administration Observation of LPN #1 completed on 01/28/2016 by the Director of Nursing. No medication error was noted during Observation. Roster of all residents receiving fast acting insulins was obtained. LPN #1 had Medication Administration Observation completed on 02/02/2016 by the Director of Nursing to ensure Fast Acting Insulin policy was Followed on all residents receiving fast acting insulin. No medication error noted during Observation.	02/7/16

Benchmark Healthcare of Puryear, Inc.
Recertification Survey
CMS Certification #: 44-5470

F333 continued:

All nursing staff was in-serviced on Novolog Insulin and policy regarding fast acting insulins on 02/17/2016 by the Director of Nursing.

The Director of Nursing and/or MDS Coordinator will perform Medication Administration Observations, with specific attention to fast acting insulin administration and times given in relation to meals/snacks, and complete audit as documentation 1 time a week for 4 weeks and then monthly as part of the facility QA.

The Director of Nursing and/or her designee will monitor corrective action through review of Medication Administration Observations and documentation of audits and any issues or concerns noted will be reported to the Administrator and corrected immediately.

The Administrator and/or her designee will monitor corrective action through review of Medication Administration observation/audits weekly for 4 weeks and then monthly.

The Director of Nursing and/or her designee will also report the results of Medication Administration observations/audit documentation and any concerns noted during the Medication Administration observation/audits during the facility monthly QA meeting.

Any future noncompliance with improper administration of fast acting insulins will be reported to the Quality Assurance/Improvement Committee by the Director of Nursing, MDS Coordinator, and/or their designee for immediate action to resolve the issue.

Completion Date: 02/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER
BENCHMARK HEALTHCARE OF PURYEAR INC

STREET ADDRESS, CITY, STATE, ZIP CODE
220 COLLEGE STREET
PURYEAR, TN 38251

(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 333	Continued From page 31 LPN #1 stated, "Maximum 15 to 20 minutes." Interview with the Director of Nursing (DON), on 1/26/16 at 5:57 PM, outside the Administrator's office, the DON was asked how long after Novolog insulin has been administered should the resident receive their meal. The DON stated, "No longer than 15 minutes 10 minutes is ideal."	F 333		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on review of daily staff posting and interview, the facility failed to ensure adequate	F 353	The Director of Nursing reviewed the Daily Staff Posting sheets on 02/08/2016 from 01/28/2016 through 02/08/2016. All shifts found to covered with no less than 3 staff members per shift (1 RN and/or LPN and 2-3 CNA). The Director of Nursing or her designee, will maintain Daily Staff Posting sheets in a binder and verify sufficient staff for each day, consisting of no less than 3 licensed staff members (RN/LPN/CNA) per shift, and sign the bottom of each shift.	02/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 353	Continued From page 32 certified staff to provide care for the residents for 4 of 4 (October, November and December, 2015 and January, 2016) months reviewed. The findings included: 1. Review of the October 2015 daily staff posting sheets, revealed 1 Licensed Practical Nurse (LPN) and 1 Certified Nursing Assistant (CNA) worked 11 PM to (-) 7 AM. The total number of residents was 29. 2. Review of the November 2015 daily staff posting sheets, revealed 1 CNA worked 11 PM-7 AM on 11/7/15 and 11/8/15. The total number of residents in the building was 31. 3. Review of the December 2015 daily staff posting sheets, revealed 1 LPN and 1 CNA worked the following dates: a. 12/3/15 with a resident census of 30. b. on 12/11/15 with a resident census of 32. c. 12/23/15 with a resident census of 29. d. 12/26/15 with a resident census of 30. e. 12/29/15 with a resident census of 31. f. 12/30/15 with a resident census of 30. g. 12/31/15 with a resident census of 30. This revealed a total of 7 night shifts that did not have sufficient staffing. 4. Review of the January 2016 daily staff posting sheets revealed 1 LPN and 1 CNA worked the 11 PM - 7 AM on the following dates: a. 1/16/16 with a resident census of 30. b. 1/17/16 with a resident census of 30. c. 1/18/16 with a resident census of 30. d. 1/22/16 with a resident census of 29. e. 1/24/16 with a resident census of 29. f. 1/27/16 with a resident census of 30.	F 353	The Director of Nursing was in-serviced 02/17/16 on 02/08/2016 by the LNHA regarding maintaining sufficient staff to consist of no less than 3 licensed staff members per shift (RN/LPN/CNA) per shift. Policy regarding Call-Ins and notification of Director of Nursing if no replacement found reviewed with the Director of Nursing on 02/08/2106. Nursing staff in-serviced on 02/17/2016 regarding Daily Staff Postings and policy on Call-In procedure. The Director of Nursing or her designee will be expected to ensure sufficient staffing as stated above is maintained and will be disciplined if noncompliant. Any future noncompliance will be reported to the Quality Assurance/ Improvement Committee by the Director of Nursing or her designee for immediate action to resolve the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 353	Continued From page 33 This revealed a total of 6 night shifts that did not have sufficient staffing. Interview with CNA #2 on 1/27/16 at 8:00 AM, in the conference room, CNA #2 was asked if she worked the night shift on 1/25/16 when Resident #24 fell. CNA #2 stated, "I worked 10 PM to 6 AM. I was working by myself that night because we were one short that night... I was here working by myself and taking care of 30 people." Interview with the Director of Nursing (DON) on 1/27/16 at 8:45 AM, in the DON's office, the DON was asked, "Who does the scheduling." The DON stated, "I do." The DON was asked how she handles call ins and who is responsible for getting someone to work if someone calls in. The DON stated, "I have told them to work on it themselves." The DON was asked what the staffing should be for the night shift. The DON stated, "I never schedule less than 1 nurse and 2 CNAs." The DON was asked what she did about the call in for the night of 1/24/16 going into 1/25/16. The DON stated, "I don't know if the CNAs took the call or if they know how to do it. CNA #3 has been having a lot of car trouble so she hasn't been able to come in for a while." The DON pointed to the master schedule where CNA #3 had been marked off on 8 previous shifts for January 2016. The DON was asked if CNA #3 had called her on 1/24/16. The DON stated, "No, I assume she was going to call in." The DON was asked if she was referring to CNA #1 who had an expired certification. The DON stated, "Yes." The DON was asked what the night shift staff should have done when they realized CNA #3 was not coming in. The DON stated, "I should have been notified and they should have tried to find someone."	F 353		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER
BENCHMARK HEALTHCARE OF PURYEAR INC

STREET ADDRESS, CITY, STATE, ZIP CODE
220 COLLEGE STREET
PURYEAR, TN 38251

(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 353	Continued From page 34 Telephone Interview with LPN #2 on 1/27/16 at 10:10 AM, in the conference room, LPN #2 was asked if she worked the night shift on 1/26/16. LPN #2 stated, "Yes, ma'am... I try to double check my aides... that night was so hectic..." Interview with the Administrator on 1/27/16 at 2:25 PM, in the conference room, the Administrator was asked if she was aware that the night shift staff had been working short handed throughout December, 2015 and January, 2016 due to CNA #3 having car trouble. The Administrator stated, "That particular subject has come up in the last two weeks with the DON that she would be expected to come in."	F 353		02/17/16
361 SS=D	483.35(a) QUALIFIED DIETITIAN - DIRECTOR OF FOOD SVCS The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis. If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian. A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs. This REQUIREMENT is not met as evidenced by:	F 361	RD visited the facility on 01/31/2016 and reviewed Resident #2 medical record. RD summary of Nutritional Care states "No diet change requested at this time however please maintain weekly wts and please reweigh on Monday, February 1 and notify Dietician of any weight loss". Resident #2 was reweighed on Monday, February 1 and gained 2.8 pounds. Resident #2 next weekly weight reveled a loss of 3.9 pounds. RD was notified and recommended House Supplement (Clear) with lunch and supper. Order obtained from MD on 02/05/2016.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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
				02/17/16
F 361	Continued From page 35 Based on policy review, review of a consulting service agreement, medical record review, observation and interview, the facility failed to ensure a Registered Dietitian (RD) assessed and implemented interventions for 1 of 2 (Resident #2) nutritionally compromised sampled residents. The findings included: The facility's "Nutrition Alert Program" policy documented, "...Residents with a history of weight loss or at nutritional risk as determined by further criteria shall be followed by the Quality Assurance Team... 4... additional approaches to increase overall calorie intake... RD [Registered dietitian] / LD [Licensed Dietician]..." The facility's "Consulting Services Agreement" documented, "...[named corporation] will provide a consulting dietician to [named facility]... Evaluate and/or review medically prescribed diets, assess and monitor nutritional status of residents and document such evaluation assessment... monitoring in medical records..." Medical record review revealed Resident #2 was admitted to the facility on 10/18/11 with diagnoses of Alzheimer's Disease, Brief Psychosis, Major Depressive Disorder, Dementia, Hypothyroidism, Generalized Anxiety Disorder and Reflux Disease without Esophagitis. Review of the annual Minimum Data Set (MDS) dated 10/4/15 revealed Resident #2 required supervision and encouragement during meals and had no weight loss. Review of quarterly MDS dated 1/14/16 revealed Resident #2 had a weight loss of 5 percent (%) or more in the last month or 10% or more in last 6 months	F 361	Dietary Committee Meeting met on 02/05/2016 and reviewed RD recommendations. Weights, diet type and supplemental orders for all residents. The Dietary Committee Meeting policy was revised to include additional calories be initiated by the Dietary Committee or RD/LD recommendations with an order from the physician on 02/05/2016 by the LNHA, Director of Nursing and Certified Dietary Manager. In-serviced Nursing Staff on the Facility Nutrition Program policy and Dietary Committee Meeting policy on 02/17/2016 by the Director of Nursing. The Director of Nursing and/or her designee will monitor all weights and refer all confirmed significant weight losses (*weight loss of five (5) percent or more in the last month or ten (10) percent or more in the last six (6) months*) or concerns to the RD for consultation and recommendation. The Director of Nursing and/or her designee will monitor compliance during monthly Dietary Committee Meeting, discuss, change, and/or address any weight losses or concerns and review new recommendations/physician orders.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 361	Continued From page 36 The "Weights" report documented Resident #2 experienced a 6.6 pound weight loss (5% loss) between 10/6/15 and 11/4/15, and a 10 pound weight loss (7% loss) between 12/12/15 and 1/11/16. The nursing care plan meeting note dated 9/23/15 documented, "...will consult with RD [Registered Dietician] for supplement recommendations..." The current care plan documented, "...potential for nutritional deficit r/t [related to] multiple food intolerances... interventions... nutritional evaluation quarterly..." Telephone interview with the RD, on 1/27/16 at 4:22 PM, in the conference room, the RD was asked when she evaluated residents in the facility. The RD stated, "In September [2015], the owner of the facility stopped reimbursing the company I work for for their services at which time I was suspended from coming to do the monthly evaluations. I kept in regular contact with the facility, reminding them of the nonpayment situation in hopes that they would take care of the bill, so I could resume my services, but he still has not paid for the services so I have not been there since then." The RD was asked about Resident #2's weight loss. The RD stated, "Have not been contacted about Resident #2 since May, 2015." Interview with the Administrator on 1/27/16 at 4:55 PM, in the Administrator's office, the Administrator was asked if she was aware they had not had a RD for the facility since September, 2015. The Administrator stated, "September [2015] was her last visit. We were notified by the RD that her services were going to be suspended	F 361	The Director of Nursing and/or Certified Dietary Manager will meet with the RD at the beginning of all facility site visits and provide lists of all dietary concerns and weight losses to ensure all necessary and appropriate assessments will be made. The Director of Nursing and/or her designee will monitor/review all RD recommendations immediately upon receipt and notify the physician for further interventions/orders. The Director of Nursing and/or her designee and Dietary Manager will monitor compliance through completion of the facility QA and any concerns will be reported to the Administrator for immediate correction. The Administrator and/or her designee will also monitor compliance of this plan of correction through review of the weekly At Risk Committee meetings and the facility monthly QA and address any concerns immediately.	02/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 361	Continued From page 37 due to lack of payment. In fact, it was a pretty significant amount of months... [consultant RD] was not paid. I contacted our home office, they handle that. I notified the Director of Operations multiple times regarding when we could expect their bill to be current so we could resume services and was told they were working on it. Over the last 3 months multiple times I have e-mailed the home office and the owner regarding this problem and both the owner and the director of operations said they realized we were out of compliance. We kept in contact with [named the RD] to see if the bill had been paid. As of several days ago a payment was finally sent. She's [RD] going to come the 31st of January if the check clears." The Administrator was asked if they had RD coverage in October, November and December, 2015. The Administrator stated, "No."	F 361	Any future noncompliance with failure to report significant weight losses to the Registered Dietician and/or Medical Director for new interventions, will be reported to the Quality Assurance/ Improvement Committee by the Director of Nursing, Certified Dietary Manager and/or their designee for immediate action to resolve issue.	02/7/16
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 accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. In accordance with State and Federal laws, the	F 431	Nystatin Topical Powder with No open dated labeled on it, was removed from the treatment cart on 01/26/2016. All topical medications located in the treatment cart where checked for proper labeling and any expired medications were discarded on 01/28/2016 by the Director of Nursing.	02/7/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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
				02/17/16
F 431	Continued From page 38 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. 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. This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, the facility failed to ensure medication was labeled when opened and were labeled with an expiration date in 1 of 4 (Treatment cart) medication storage areas. The findings included: Review of the facility's "Labeling Medications" policy documented, "...7. Medications vials/bottles will be labeled with the date they were opened (seal broken) to ensure proper tracking for expiration purposes..." Observations of the treatment cart on 1/26/16 at 11:05 AM, located across from the nurses' station, revealed an opened bottle of nystatin topical powder 30 grams not labeled with an opened date or expiration date.	F 431	A daily check of topical medications in the Treatment Cart will be completed by the night shift charge nurse every night. Compliance will be monitored by the Director of Nursing or her designee through documentation review of the treatment cart audit log 3 times weekly for 4 weeks, then monthly ongoing and address any identified immediately. Any issues identified will also be reported to the Administrator to ensure immediate correction. All licensed nursing staff were in-serviced on the policies regarding "Medication Storage", "Labeling Medications" and the Expired Medication Checklist for Treatment Cart on 02/17/2016 by the Director of Nursing. The Director of Nursing will additionally monitor compliance of this plan of correction through completion of the facility monthly QA and any concerns will be reported to the Administrator for immediate correction. The Administrator will also monitor compliance of this plan of correction through review of the facility monthly QA and address any concerns immediately	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 431	Continued From page 39 Interview with Licensed Practical Nurse (LPN) #1 on 1/26/16 at 11:08 AM, at the nurses' station, LPN #1 was asked if she saw an expiration date on the nystatin powder. LPN #1 stated, "No, I don't." LPN #1 was asked if a medication is opened should it have an open date on it. LPN #1 stated, "Yes." LPN #1 was asked how long is medication good for if opened. LPN #1 stated, "Depends on what it is. Pharmacy says 60 days."LPN #1 confirmed there was not an expiration date or an open date on the opened nystatin powder. Interview with Director of Nursing (DON) on 1/26/16 5:57 PM, outside the Administrator's office, the DON was asked what is the procedure when opening a medication. The DON stated, "Date it." The DON was asked what is procedure for opened medications that do not have an expiration date on them. The DON stated, "It's a year from date opened."	F 431	Any future noncompliance with expired topical medications will be reported to the Quality Assurance/Improvement Committee by the Director of Nursing or her designee for immediate action to resolve.	02/17/16
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to maintain 2 of 2 essential equipment (clip alarms) for residents as evidenced by a clip alarm with a battery compartment cover missing with the batteries held in place by strips of bandage tape and a clip alarm with the battery compartment cover taped with strips of bandage	F 456	Body Alarms for Residents #26 and #13 were replaced with new body alarms in good operating condition on 01/27/2016 by the Director of Nursing.	02/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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
				021716
F 456	Continued From page 40 tape. The findings included: 1. Observations in the hall near the common area on 1/27/15 at 9:46 AM, revealed Resident #26 sitting in a wheelchair with a clip alarm attached to the back of the wheelchair. The clip alarm did not have a battery compartment cover, and the batteries were held in place with strips of bandage tape. 2. Observations in the common area on 1/27/15 at 9:48 AM, revealed Resident #13 sitting in a wheelchair in the common area with a clip alarm clipped to the back of the wheelchair. The clip alarm battery compartment cover was held in place by strips of bandage tape. 3. Interview with Certified Nursing assistant (CNA) #2 on 1/27/16 at 8:00 AM, in the conference room, CNA #2 was asked about maintenance on the clip alarms. CNA #2 stated, "Half the time they don't work. They have tape on the back where the cover is missing and batteries will come out. The backs are missing so they don't hold the batteries in." Interview with the Administrator on 1/27/16 at 2:25 PM, in the conference room, the Administrator was asked if she was aware that some of the clip alarms were taped with bandage tape to keep the batteries in place. The Administrator stated, "That's news to me." Telephone interview with the Medical Director (MD) on 1/27/16 at 9:40 PM, the MD was asked if he was aware that some clip alarms were missing battery covers and bandage tape was being used	F 456	Checked Body Alarms in use by all residents to ensure they were in proper operating condition. Any Body Alarm that had no battery compartment cover or missing clips were immediately replaced by Director of Nursing on 02/01/2016. Staff in-serviced on "Alarm Check" policy and location of Fall Prevention Supplies in the supply room on 02/17/2016 by the Director of Nursing. Body Alarm Checks added to MAR to ensure all are in good operating condition on 02/01/2016 by the Director of Nursing. New Fall Prevention Supplies and Body Alarms order by the Director of Nursing on 02/04/2016. All new supplies placed in supply room on shelf designated as Fall Prevention Supplies by the Director of Nursing on 02/12/2016. Supplies will be monitored by the Director of Nursing or her designee by reviewing the Fall Equipment Log weekly to ensure there is at least 1 of each item in s tock at all times. Any new supplies that are needed to replace defective equipment or to have the minimum in stock, will be ordered by the Director of Nursing or her designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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
				02/7/16
F 456	Continued From page 41 to hold the batteries in. The MD stated, "That is totally inappropriate..."	F 456	**Any future noncompliance with malfunctioning equipment will be reported to the Quality Assurance/Improvement Committee by the Director of Nursing or her designee for immediate action to resolve.**	
F 490 SS=H	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on policy review, review of daily staff posting, review of a consulting service agreement, medical record review, review of incident reports, review of fall investigation reports, observation and interview, the facility failed to be administered in a manner to implement appropriate interventions for each fall, failed to follow the policy related to falls, which resulted in actual harm to Residents #6, 24, and 26. The facility failed to ensure administration obtained the services of a Registered Dietician for Resident #2 with significant weight loss; administration failed ensure care plans were developed and implemented to meet the needs of the resident; administration failed ensure medications were administered to maintain resident's highest level of care, and administration failed to ensure the quality assurance program was effective in identifying issues and concerns within the facility. The findings included: 1. Administration failed to ensure the staff	F 490	02/7/16 Post Survey Meeting conducted on 01/28/2016 (the day following the Survey Team's exit on 01/27/2016) with Department Supervisors: Director of Nursing, MDS Coordinator, Therapy Supervisor, Certified Dietary Manager, Activity/Social Services Director, Maintenance Supervisor, Housekeeping/Laundry Supervisor, and Business Office Manager. The meeting was conducted by the LNHA to review all cited deficiencies and begin implementing policies and procedures for the Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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
				02/17/16
F 490	Continued From page 42 followed the facility's fall prevention policy related to implementing appropriate interventions after a fall, updated the care plan for a fall and review resident falls during the weekly risk management committee meetings for Residents #24, 26 and 6. The failure of the facility to follow the policy and implement appropriate interventions after each fall and to have an occupational therapy evaluation for gait training and implementation of a treatment plan resulted in actual harm. The facility failed to ensure a body alarm was attached as care planned which resulted in actual harm when Resident #24 fell while getting out of bed sustaining a fractured nose on 1/25/16. The failure to implement a new intervention after each fall resulted in actual harm when Resident #26 fell again sustaining a left hip fracture on 6/2/15. The facility failed to ensure an evaluation was completed for gait training resulted in actual harm when Resident #6 fell again, sustaining a laceration that required sutures on 9/26/15. Refer to F323. 2. Administration failed to ensure assessments were done accurately and care plans were developed and implemented to meet the needs of the resident. Refer to F278, F280 and F282. 3. Administration failed to ensure there was sufficient staffing. Interview with the Administrator on 1/26/16 at 3:40 PM, in the Administrator office, the Administrator was asked if Certified Nursing Assistant (CNA) #1 had worked this week. The Administrator stated, "Yes, she's been doing	F 490	Mandatory Post Survey Meetings were scheduled for all personnel on February 3, 2016 at 8am or 2pm and February 4, 2016 at 8am or 2pm. All employees attended one of the meeting sessions held by the LNHA. All deficiencies cited were reviewed and employees made aware of the additional in-services and training that they will be required to attend. LNHA updated the daily Community Report on 02/08/2016 to reflect Falls, Therapy Screen Requests, Equipment Concerns, and Staff Call-Ins with Replacements Scheduled. Information for the report will be obtained from Department Supervisors in our daily meeting to ensure all issues are addressed. LNHA implemented "At Risk" Committee Meeting to be held weekly with the LNHA, Director of Nursing, Certified Dietary Manager, and MDS Coordinator to aid in identifying falls, weight losses, and other resident issues that need to be addressed. The Quality Assurance/Improvement Committee meetings will track random medication reviews and/or medication errors to ensure proper educating	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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
				021716
F 490	Continued From page 43 personal care, baths, transfers and helped feed residents." The Administrator was asked if CNA #1's certification had an expired. The Administrator stated, "It is." Interview with the Administrator on 1/27/16 at 2:25 PM, in the conference room, the Administrator was asked if she was aware that the night shift staff had been working short handed throughout December, 2015 and January, 2016 due to CNA #3 having car trouble. The Administrator stated, "That particular subject has come up in the last two weeks with the DON... she would be expected to come in." Refer to F353 and F499. 4. Administration failed to identify, develop and implement appropriate plans of action to correct, monitor and reassess identified quality concerns in Quality Assurance and Assessment meetings. Interview with the Administrator on 1/27/16 at 2:25 PM, in the conference room, the Administrator was asked if she was aware that some of the clip alarms were taped with bandage tape to keep the battery covers on or to take the place of the battery covers. The Administrator stated, "That's news to me." The Administrator was asked where the CNAs document what they do for residents and their rounds and alarm checks. The Administrator stated, "At one time we had it on the MARs [Medication Administration Records]. The DON said no to that so we took it off. It needs to be somewhere where they can document it." Refer to F323, F456 and F520.	F 490	is given to Licensed Nurses and Care Plan updates are completed as needed. All above was in-serviced to Department Supervisors on 02/16/2016 by the LNHA. The LNHA or her designee will ensure the daily Community Report, At Risk Committee Meeting and Quality Assurance/Improvement Committee Meetings are completed in a timely manner. Any noncompliance with documentation or lack of meeting compliance will be reported to the Quality Assurance/Improvement Committee Meeting by the LNHA or her designee for immediate action to resolve. Amendment to POC 02/17/2016 F490 H- A daily Community Report is being completed Monday through Friday of each week, with Mondays report including weekend information as applicable. Director of Nursing is reporting any absences by licensed staff and noting how that position was replaced. Falls are reviewed with during the morning meeting with noted decline noted in reported falls since the last survey.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445470	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/27/2016
NAME OF PROVIDER OR SUPPLIER BENCHMARK HEALTHCARE OF PURYEAR INC		STREET ADDRESS, CITY, STATE, ZIP CODE 220 COLLEGE STREET PURYEAR, TN 38251	

(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 490	Continued From page 44 5. Administration failed to ensure a transdermal patch was administered correctly when nursing staff failed to clean the application site for 1 of 1 (Resident #3) resident observed receiving a transdermal patch during the medication administration pass. Refer to F309. 6. Administration failed to ensure a resident was free of a significant medication error when 1 of 2 nurses (Licensed Practical Nurse (LPN) #1) failed to administer insulin within the proper time frame related to meals for Resident #4, who received an insulin injection. Refer to F333. 7. Administration failed to ensure a Registered Dietitian (RD) assessed and implemented interventions for 1 of 2 (Resident #2) nutritionally compromised sampled residents. Refer to F361 and F500.	F 490	Amendment con't Since last survey, Fall Investigation reports have been completed on all residents with a reported fall. Reports include BIMs score, initial root cause and immediate intervention. Reports are reviewed and signed by the Director of Nursing, LNHA, and Medical Director. Interventions for all falls have been updated to the resident's Care Plan and Kardex. Con't to Amendment to next page	
F 493 SS=D	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility	F 493		

Amendment to POC 02/17/2016 continued:

F490 H

Facility has conducted At Risk Meetings every week since last survey. Meetings were conducted on 02/19/2016, 02/26/2016, 03/04/2016, 03/11/2016, 03/18/2016, 03/25/2016, 04/01/2016, 04/08/2016, 04/15/2016, and 04/21/2016. Weight Summary Report is reviewed at that time, along with falls with interventions, and therapy referrals. Weekly minutes are reviewed by the Medical Director.

The Director of Nursing continues ensure sufficient staffing by monitoring the Daily Staffing and ensuring replacements are found for any shift with a staff shortage.

Random medication reviews have been completed as follows:
02/02/2016 – Fast Acting Insulin administration checked on 2 residents with LPN #1 by Director of Nursing – procedure followed.
02/04/2016 – Transdermal Patch check with LPN #1 by Director of Nursing – procedure followed.
03/09/2016 – Fast Acting Insulin administration check with LPN #1 by MDS Coordinator – procedure followed.
03/09/2016 – Transdermal Patch check with LPN #1 by MDS Coordinator – procedure followed.

The RD has visited the facility on 01/31/2016, 02/28/2016, and 03/31/2016. RD visit from 01/31/2016 included a review of all resident records with recommendations as necessary. Following the RD visits, Dietary Committee Meetings were conducted on 02/05/2016, 03/10/2016, and 04/10/2016, with Medical Director notified for orders. All diets and supplements were reviewed at each Dietary Committee Meeting to ensure orders are properly followed.

The above has been monitored by the Quality Assurance/Improvement Committee on 02/26/2016, 03/23/2016 and 04/14/2016 to ensure POC for above followed. Quality Assurance/Improvement meeting minutes updated to reflect the current citations to be monitored.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 493	Continued From page 45 This REQUIREMENT is not met as evidenced by: Based on policy review, review of a consulting service agreement, medical record review, observations, and interview, the governing body failed to ensure the facility was governed in a manner that enabled the facility to use its resources effectively and efficiently to attain or maintain the highest practical physical well-being when the facility failed to ensure a Registered Dietitian (RD) assessed and implemented interventions for 1 of 2 (Resident #2) nutritionally compromised sampled residents. The findings included: The facility's "Nutrition Alert Program" policy documented, "...Residents with a history of weight loss or at nutritional risk as determined by further criteria shall be followed by the Quality Assurance Team... 4... additional approaches to increase overall calorie intake... RD [Registered Dietitian] / LD [Licensed Dietician]..." The facility's "Consulting Services Agreement" documented, "...[named corporation] will provide a consulting dietician to [named facility]... Evaluate and/or review medically prescribed diets, assess and monitor nutritional status of residents and document such evaluation assessment... monitoring in medical records..." The facility was aware that residents at nutritional risk had not been evaluated and interventions developed to minimize weight loss. Resident #2's quarterly Minimum Data Set (MDS) dated 1/14/16 revealed Resident #2 had a weight loss of 5 percent (%) or more in the last month or 10% or more in last 6 months.	F 493	LNHA spoke with Registered Dietician on the telephone on 01/28/2016. she stated that services to the facility would be resumed, as payment had been received. Scheduled visit with facility on 01/31/2016. Resident #2 was seen by the Registered Dietician on 01/31/2016. Registered Dietician and CDM reviewed Resident #2 medical record, including weights and intakes. Registered Dietician made notation on Summary of Nutritional Care for Resident #2, stating "No diet change requested at this time however please maintain weekly weights and please re weigh on Monday February 1 and notify Dietician of any wt loss. and RD to follow up PRN". Registered Dietician had made note on Resident #2 that "currently wt loss positive". Resident #2 was reweighed on 02/01/2016 as requested and had a weight gain of 2.8 pounds. Resident #2 then reweighed on 02/05/2016 (weekly weight schedule), and had lost 3.9 pounds. Registered Dietician was notified and RD recommended a "clear house supplement lunch and supper tray".	02/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 493	Continued From page 46 Telephone interview with the consultant Registered Dietitian (RD), on 1/27/16 at 4:22 PM, in the conference room, the RD was asked when she evaluated residents in the facility. The RD stated, "In September [2015], the owner of the facility stopped reimbursing the company I work for for their services at which time I was suspended from coming to do the monthly evaluations. I kept in regular contact with the facility, reminding them of the nonpayment situation in hopes that they would take care of the bill, so I could resume my services, but he still has not paid for the services so I have not been there since then." The RD was asked about Resident #2's weight loss. The RD stated, "Have not been contacted about Resident #2 since May, 2015." Interview with the Director of Nursing (DON) on 1/27/16 at 6:39 PM, outside of the Administrator's office, the DON was asked at what point does the RD provide recommendations for a significant weight loss in October [2015]. The DON stated, "The RD was not here in November [2015]. She has not been here since September [2015]." Interview with the Administrator on 1/27/16 at 4:55 PM, in the Administrator's office, the Administrator was asked if she was aware they had not had a Registered Dietician for the facility since September, 2015. The Administrator stated, "September [2015] was her last visit. We were notified by the RD that her services were going to be suspended due to lack of payment. In fact, it was a pretty significant amount of months... [the consultant RD] was not paid... I contacted our home office, they handle that. I notified the Director of Operations multiple times regarding	F 493	Primary physician was notified and orders received for the above recommendations. Registered Dietician and CDM reviewed all weights, diets, and intakes for all of the residents residing in the facility on 01/31/2016. Recommendations made on 14 of 30 residents. Director of Nursing notified MD and orders received on all recommendations on 02/05/2016. LNHA, Business Office Manager, or their designee will ensure invoices for Registered Dietician Services are forwarded to the facility's Accounts Payable Department each month. LNHA, Business Office Manager or their designee will follow-up with Accounts Payable Department and/or the facility's owner by either daily Community Report or email to ensure payment for Dietician Services is paid promptly. If previous invoice for services is not paid timely, LNHA will contact facility's owner to	02/16

Amendment to POC 02/17/2016

F493 D
As of the last survey, Registered Dietician has visited the facility on the following dates: 01/31/2016, 02/28/2016, 03/31/2016, and 04/21/2016. On the 01/31/2016, RD reviewed the medical records, weights and diets of all resident residing in the facility. Dietary Committee Meetings were held following each month's visit with recommendations forwarded to the Medical Director and orders received.
Invoices from Healthcare Technologies for the above months RD visits were posted into PointClickCare for Accounts Payable Department to issue a check for payment. Facility has made all payments timely and there has been no disruption of RD services.

Benchmark Healthcare of Puryear, Inc.
Recertification Survey
CMS Certification #: 44-5470

F493 continued:

The facility's Governing Body includes John Sells, Owner/Operator, Trish Kincade, Chief Nursing Officer, Karen Lancaster, Administrator, Christy Runyon, Director of Nursing and Dr. James W. McGee, Medical Director. The owner/operator has hired a full-time Corporate Nurse/Chief Nursing Officer, who will be assisting the administrator with overseeing this plan of correction through site visits made at least monthly, or more frequently as needed and through weekly phone calls with the facility administrator.

The administrator will monitor all aspects of this plan of correction and report to the Governing Body through the facility quarterly QA. Any concerns or issues noted will be reported to the Governing Body, and specifically the Chief Nursing Officer, and addressed immediately. The Chief Nursing Officer will monitor this plan of correction through site visits made at least monthly, or more frequently as needed and through weekly phone calls with the facility administrator.
Additionally, the Governing Body will monitor this plan of correction through review of compliance during the facility monthly QA and any issue or concerns addressed immediately.

Completion date: 02/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 493	Continued From page 47 when we could expect their bill to be current so we could resume services and was told they were working on it. Over the last 3 months multiple times I have e-mailed the home office and the owner regarding this problem and both the owner and the director of operations said they realized we were out of compliance. We kept in contact with [named the RD] to see if the bill had been paid. As of several days ago a payment was finally sent. She's going to come the 31st of January if the check clears." The Administrator was asked if they had RD coverage in October, November and December, 2015. The Administrator stated, "No." The failure to manage facility resources had a direct impact on resident care, treatment and services. Refer to F280 and F500.	F 493	request immediate payment. Current invoice for Dietician Services for 01/31/2016 visit, was submitted to Accounts Payable Department on 02/12/2016 by LNHA. Any future noncompliance with suspended Dietician Services will be reported to the Quality Assurance/Improvement Committee by the LNHA and/or designee for immediate action to resolve. Accounts Payable and/or owner will also be notified.	021716
F 499 SS=D	483.75(g) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on license review and interview, the facility failed to ensure that professional staff were certified in accordance with applicable State laws for 1 of 5 Certified Nursing Assistant (CNA	F 499	CNA #1 had Nurse Aide License renewed, with expiration date of 01/20/2018. All CNA licenses were verified on the Tennessee Department of Health's Licensure Verification website on 02/18/2016 by the Business Office/ Personnel Manager. All employed CNAs have current CNA licenses.	021816

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 499	Continued From page 48 #1) new hires reviewed. The findings included: Review of the State of Tennessee Department of Health Division of Health Licensure and Regulation Tennessee Nurse Aide Registry revealed a lapsed CNA certification for CNA #1. License number 59614 for CNA #1 expired 1/20/16 with a status documented, "...Lapsed..." Interview with the Administrator on 1/26/16 at 3:40 PM, in the Administrator office, the Administrator was asked if CNA #1 had worked this week. The Administrator stated, "Yes, she's been doing personal care, baths, transfers and helped feed residents." The Administrator was asked if CNA #1's certification had an expired. The Administrator stated, "It is." Interview with Licensed Practical Nurse (LPN) #1 on 1/26/16 at 3:45 PM, in the conference room, LPN #1 was asked if CNA #1 had worked in the facility today. LPN #1 stated, "Yes, she passed ice, toileted people, helped with showers, did vital signs and assisted with meals. She got people up and took them to the dining room." Interview with the Director of Nursing (DON) on 1/27/16 at 8:40 AM, in the DON's office, the DON was asked who makes sure nursing staff licenses and certifications are kept up to date. The DON stated, "I do." The DON was asked if CNA #1's certification had expired. The DON stated, "Yes."	F 499	02/8/16 The Director of Nursing or her designee will ensure that all CNAs have current licenses. The Director of Nursing or her designee will maintain an employee roster with Certifications and Expiration Dates for all licensed staff. Any noncompliance with maintaining current CNA licenses will be reported to the Quality Assurance/Improvement Committee by the Director of Nursing. Any CNA noted to have an expired CNA license will be removed from the schedule until license verified that it is current.	
F 500 SS=D	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified	F 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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
				021716
F 500	Continued From page 49 professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h)(2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on policy review, review of a consulting service agreement, medical record review, observation and interview, the facility failed to ensure a Registered Dietitian (RD) assessed and implemented interventions for 1 of 2 (Resident #2) nutritionally compromised sampled residents. The findings included: The facility's "Nutrition Alert Program" policy documented, "...Residents with a history of weight loss or at nutritional risk as determined by further criteria shall be followed by the Quality Assurance Team... 4... additional approaches to increase overall calorie intake... RD [Registered Dietitian] / LD [Licensed Dietician]..." The facility's "Consulting Services Agreement" documented, "...[named corporation] will provide	F 500	LNHA spoke with Registered Dietician on the telephone on 01/28/2016. she stated that services to the facility would be resumed, as payment had been received. Scheduled visit with facility on 01/31/2016. Resident #2 was seen by the Registered Dietician on 01/31/2016. Registered Dietician and CDM reviewed Resident #2 medical record, including weights and intakes. Registered Dietician made notation on Summary of Nutritional Care for Resident #2, stating "No diet change requested at this time however please maintain weekly weights and please re weigh on Monday February 1 and notify Dietician of any wt loss. And RD to follow up PRN". Registered Dietician had made note on Resident	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 500	Continued From page 50 a consulting dietician to [named facility]... Evaluate and/or review medically prescribed diets, assess and monitor nutritional status of residents and document such evaluation assessment... monitoring in medical records..." Medical record review revealed Resident #2 was admitted to the facility on 10/18/11 with diagnoses of Alzheimer's Disease, Major Depressive Disorder, Brief Psychosis, Dementia, Hypothyroidism, Generalized Anxiety Disorder and Reflux Disease without Esophagitis. Review of the annual Minimum Data Set (MDS) dated 10/4/15 revealed Resident #2 required supervision and encouragement during meals and Resident #2 had no weight loss. Review of quarterly MDS dated 1/14/16 revealed Resident #2 had a weight loss of 5 percent (%) or more in the last month or 10% or more in last 6 months The "Weights" report documented Resident #2 experienced a 6.6 pound weight loss (5% loss) between 10/6/15 and 11/4/15, and a 10 pound weight loss (7% loss) between 12/12/15 and 1/11/16. The nursing care plan meeting note dated 9/23/15 documented, "...will consult with RD for supplement recommendations..." The current care plan documented, "...potential for nutritional deficit r/t [related to] multiple food intolerances... interventions... nutritional evaluation quarterly..." Telephone interview with the RD, on 1/27/16 at 4:22 PM, in the conference room, the RD was asked when she evaluated residents in the facility. The RD stated, "In September [2015], the owner of the facility stopped reimbursing the	F 500	#2 that "currently wt loss positive". Resident #2 was reweighed on 02/01/2016 as requested and had a weight gain of 2.8 pounds. Resident #2 then reweighed on 02/05/2016 (weekly weight schedule and had lost 3.9 pounds. Registered Dietician was notified and RD recommended a "clear house supplement lunch and supper tray". Primary physician was notified and orders received for the above recommendations. Registered Dietician and CDM reviewed all weights, diets, and intakes for all of the residents residing in the facility on 01/31/2016. Recommendations made on 14 of 30 residents. Director of Nursing notified MD and orders received on all recommendations on 02/05/2016.	02/01/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 500	Continued From page 51 company I work for for their services at which time I was suspended from coming to do the monthly evaluations. I kept in regular contact with the facility, reminding them of the nonpayment situation in hopes that they would take care of the bill, so I could resume my services, but he still has not paid for the services so I have not been there since then." The RD was asked about Resident #2's weight loss. The RD stated, "Have not been contacted about Resident #2 since May, 2015." Interview with the Administrator on 1/27/16 at 4:55 PM, in the Administrator's office, the Administrator was asked if she was aware they had not had a Registered Dietician for the facility since September, 2015. The Administrator stated, "September [2015] was her last visit. We were notified by the RD that her services were going to be suspended due to lack of payment. In fact, it was a pretty significant amount of months Healthcare Technologies was not paid. I contacted our home office, they handle that. I notified the Director of Operations multiple times regarding when we could expect their bill to be current so we could resume services and was told they were working on it. Over the last 3 months multiple times I have e-mailed the home office and the owner regarding this problem and both the owner and the director of operations said they realized we were out of compliance. We kept in contact with [named the RD] to see if the bill had been paid. As of several days ago a payment was finally sent. She's going to come the 31st of January if the check clears." The Administrator was asked if they had RD coverage in October, November and December, 2015. The Administrator stated, "No."	F 500	LNHA, Business Office Manager, or their designee will ensure Invoices for Registered Dietician Services are forwarded to the facility's Accounts Payable Department each month. LNHA, Business Office Manager or their designee will follow-up with Accounts Payable Department and/or the facility's owner by either daily Community Report or email to ensure payment for Dietician Services Is paid promptly. If previous invoice for services is not paid timely, LNHA will contact facility's owner to request immediate payment. Current invoice for Dietician Services for 01/31/2016 visit, was submitted to Accounts Payable Department on 02/12/2016 by LNHA. Any future noncompliance with suspended Dietician Services will be reported to the Quality Assurance/Improvement Committee by the LNHA and/or designee for immediate action to resolve. Accounts Payable and/or owner will also be notified.	02/17/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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
				021816
F 501 F 501 SS=H	Continued From page 52 483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, review of incident reports, review of fall investigation reports, review of Quality Assurance (QA) Committee minutes and sign in sheets, observation, and interview, the facility failed to ensure the medical director (MD) assisted the facility with identifying and evaluating clinical concerns and failed to coordinate the medical care and provide clinical guidance and oversight regarding the implementation of resident care procedures. The facility failed to follow their fall policy and ensure the Medical Director assisted with addressing clinical concerns and provide guidance regarding resident care of the residents in the facility by failing to ensure there was appropriate interventions related to falls. The facility failed to ensure a body alarm was attached as care planned which resulted in actual harm when Resident #24 fell while getting out of bed sustaining a fractured nose on 1/25/16. The failure to implement a new intervention after each fall resulted in actual harm when Resident #26 fell again sustaining a left hip fracture on 6/29/15. The facility failed to ensure an evaluation was completed for gait training resulted in actual harm when Resident #6 fell again, sustaining a	F 501 F 501	LNHA met with Medical Director in his clinic on 02/02/2016. Discussed with Medical Director falls that occurred to Resident #6, #24, and #26. Reviewed care plans and orders for the above residents to ensure all interventions were appropriate. Previous falls reported on all residents in the last 3 month's Quality Assurance/Improvement Committee meeting minutes were reviewed with Medical Director on 02/02/2016. Reviewed revised care plan interventions put into place since exit of survey team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 501	Continued From page 53 laceration that required sutures on 9/26/15. The findings included: The facility's "Quality Improvement Committee Meeting Attendance Sign-in" sheets dated 11/24/15, 12/17/15, and 1/20/16 documented the medical director was in attendance. Review of the facility's "Incident by Incident Type" form attached to the 11/24/15 Quality Improvement Committee Meeting sign-in sheet, revealed 16 fall incidents with 3 of those falls resulting in resident injury and documented, "...Above IR [incident review] reviewed/discussed with Medical Director." Review of the facility's "Incident by Incident Type" form attached to the 12/17/15 Quality Improvement Committee Meeting sign-in sheet, revealed 11 fall incidents with 6 of those falls resulting in resident injury and documented, "...above IR reviewed and discussed with Medical Director." Review of the facility's "Incident by Incident Type" form attached to the 1/20/16 Quality Improvement Committee Meeting sign-in sheet, revealed 14 fall incidents with 4 of those falls resulting in resident injury and documented, "...above IR reviewed/discussed with MD." Telephone interview with Medical Director on 1/27/16 at 9:40 PM, the MD was asked if he had any concerns with falls at the facility. The MD stated, "Well, I've always got concerns with falls." The MD was asked if he was concerned about the inordinate amount of falls at the facility? The MD stated, "I wasn't aware of it. I don't know the	F 501	Medical Director in-serviced on facility's procedure in reporting falls and ensuring an appropriate intervention is ordered with each fall reported on 02/18/2016 by the LNHA. Medical Director to review and sign all Fall Investigation Reports. Weekly and monthly Fall Analysis Reports will be given to the Medical Director to review and sign. Any additional interventions necessary will be addressed at that time. Medical Director will review and sign all At Risk Meeting minutes and address any new interventions if necessary. Any future noncompliance of Medical Director's failure to identify and evaluate clinical concerns will be reported to the Quality Assurance/Improvement Committee by the LNHA or her designee for immediate action to resolve the issue.	021814

Amendment to POC 02/17/2016

F501 H

Since the last survey, the Medical director was in-serviced on the facility's Fall Investigation Reports and when he is notified regarding a fall, he ensures that an intervention is immediately put into place. All Fall Investigation Reports have been reviewed and signed by the Medical Director. He also reviews and signs the additional Quality Assurance reports:

1. Monthly Fall Analysis Logs from January, February and March of 2016
2. Weekly At Risk Committee Meetings Minutes, which include the Weekly Fall Analysis Logs from 02/19/2016, 02/26/2016, 03/04/2016, 03/11/2016, 03/18/2016, 03/25/2016, 04/01/2016, 04/08/2016, 04/15/2016 and 04/21/2016.
3. Quality Assurance/Improvement Meetings from 02/26/2016, 03/23/2016 and 04/14/2016

The Quality Assurance/Improvement Committee and At Risk Committee has monitored all falls since the last survey and noted that all falls have initiated an appropriate intervention. The facility has also noted a decline in falls since the last survey, as noted in Amendment to POC F280.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 501	Continued From page 54 average percentage of falls in facilities but I don't think we have an inordinate amount, with most of the falls it turns out they just slid down the wall and fell on their bottom." The MD was asked if he was aware that some clip alarms were missing battery covers and bandage tape was being used to hold the batteries in. The MD stated, "That is totally inappropriate..." The MD was asked if they discussed falls in Quality Assurance. The MD stated, "Not that I recall, not a significant increase in falls." The MD was asked if he was aware that the Occupational Therapist did evaluations and screenings for residents, but did not always document them in the resident record? MD stated, "No."	F 501		
F 520 SS=H	Refer to F323. 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the	F 520	The Quality Assurance/Improvement Committee met on 02/19/2016. Members attending included a representative from each facility department: Medical: Medical Director Administrative: LNHA Nursing: Director of Nursing MDS: MDS Coordinator Dietary: Certified Dietary Manager Maintenance: Maintenance Supervisor Housekeeping/Laundry: Housekeeping/Laundry Supervisor Activities: Activity Director Social Services: Social Service Director Business Office: Business Office Manager	02/19/16

RECEIVED
JUN 08 2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER
BENCHMARK HEALTHCARE OF PURYEAR INC

STREET ADDRESS, CITY, STATE, ZIP CODE
220 COLLEGE STREET
PURYEAR, TN 38251

(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 520	Continued From page 55 compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on policy review, review of occurrence reports and investigations, review of staffing patterns, medical record review, observation and interview, the Quality Assessment and Assurance (QAA) committee was ineffective in identifying issues and concerns within the facility. The QAA committee failed to identify issues, develop and implement appropriate plans of action to correct quality deficiencies related to the facility not following their fall policy, not implementing appropriate interventions after each fall and failed to ensure an occupational or physical therapy evaluation was completed for gait training and implementation of a treatment plan which resulted in actual harm. The facility failed to ensure a body alarm was attached as care planned which resulted in actual harm when Resident #24 fell while getting out of bed sustaining a fractured nose on 1/25/16. The facility failed to implement a new intervention after each fall resulted in actual harm when Resident #26 fell again sustaining a left hip fracture on 6/29/15. The facility failed to ensure an evaluation was completed for gait training resulted in actual harm when Resident #6 fell again, sustaining a laceration that required sutures on 9/26/15. The findings included:	F 520	Discussed areas of concern: care plan interventions that are appropriate, care plans that are updated and revised appropriately, maintaining an environment free of accident hazards, sufficient staffing, current certifications of licensed staff, and Registered Dietician services. Each area was reviewed and policies and procedures updated, new systems put in to place, and staff educated on areas of concern (as stated in previous plans of correction). On 02/19/2016, the Quality Assurance/Improvement Committee reviewed the last 3 months of falls and weight losses to ensure appropriate interventions in place. New equipment was ordered to replace any faulty equipment or equipment in poor working condition. Any faulty equipment was replaced (as previously stated). All Licensed staff certifications were checked for current licensure on 02/18/2016 by the Business Office Manager. None were found to have expired. Registered Dietician resumed services to the facility on 01/31/2016 and reviewed all current residents	02/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	445470		01/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HEALTHCARE OF PURYEAR INC	220 COLLEGE STREET PURYEAR, TN 38251

(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 520	Continued From page 56 1. The QAA committee failed to ensure care plan interventions were appropriate, revised, and followed by nursing staff to prevent falls and to prevent weight loss. Refer to F280, F282, F323, and F361. 2. The QAA committee failed to ensure that residents were protected from accident hazards related to falls resulting in actual harm for Residents #6, 24, and 26. Refer to F323. 3. The QAA committee failed to ensure the facility had sufficient staffing to care for residents or ensure a nursing assistant did not work after their certification had expired. Refer to F353 and F499. 4. The QAA committee failed to ensure Registered Dietitian (RD) services were provided. Refer to F280, F361, and F500. 5. Interview with the Administrator on 1/27/16 at 9:36 PM, in the Administrator's office, the Administrator was asked if the QAA committee had identified any clinical or medical issues. The Administrator stated, "Yes, did have concerns about falls, tried to look at root cause, one particular resident falling a lot."	F 520	medical records. Recommendations were made if needed and orders were obtained by the Medical Director (as previously stated). Quality Assurance/Improvement Committee was in-serviced on the new procedures:	D2194

RECEIVED
JUN 08 2016

Continuation of F520 Completion Date: 02/19/2016

Fall tracking – to be monitored by the Medical Director, LNHA, Director of Nursing and/or their designee. Facility will track falls using the "Fall Analysis Log" to be completed weekly and the "Monthly Fall Analysis" to be completed monthly. Reports will be completed by the LNHA, Director of Nursing, or their Designee and forwarded to the Medical Director for his review and signature. Fall Prevention Equipment – All fall prevention equipment, such as body alarms, bed alarms/sensors, floor mats, etc, will be maintained by the Director of Nursing or her designee. The Director of Nursing or her designee will maintain an equipment log in the supply room to account for all fall prevention equipment on hand and in use. The Director of Nursing or her designee will monitor supply count and order new supplies as needed. The Maintenance Supervisor or his designee will address any faulty equipment for repairs or to dispose of. Weight losses will be reviewed by the Registered Dietician on her monthly visit to the facility. Weight losses will also be monitored by the Dietary Committee monthly. Nursing staff in-serviced on 02/17/2016 by the Director of Nursing posting staffing information, call-in procedure, and attendance policy. Director of Nursing or her designee to monitor/maintain working schedule and staff postings to ensure adequate/ sufficient staff/resident ratio. Director of Nursing or her designee will maintain an employee roster for all licensed staff and ensure certifications are current. LNHA, CDM and/or their designee will communicate with Registered Dietician monthly to ensure visits will be made to the facility. Any issues with delinquent payment resulting in suspension of services will be reported to the Accounts Payable department and/or owner.

Any future noncompliance with failure of Department Supervisors to address areas of concern for their departments will be reported to the Quality Assurance/Improvement Committee by the appropriate department supervisor for immediate action to resolve the issue.

Amendment to POC 02/17/2016

F520 H
The Quality Assurance/Improvement Committee met on 02/26/2016, 03/23/2016, and 04/14/2016.
Updated Quality Assurance/Improvement form used that included all citations from 01/27/2016 survey to ensure committee is monitoring all areas of concern for improvement.
The committee continues to use the following tools for the purpose of tracking and identifying any current or future concerns (see dates of below meetings in previous amendments):
Weekly At Risk Committee Meeting
Weekly Fall Analysis Log
Monthly Fall Analysis
Monthly Dietary Committee Meeting
Daily Staffing Sheets

The facility communicates with the Medical Director when a fall occurs and Fall Investigation forms have been completed, reviewed and signed by the Director of Nursing, LNHA, and the Medical Director to ensure interventions are appropriate.

The facility communicates with the RD for scheduling of monthly visits and the LNHA has communicated to the facility's Accounts Payable department regarding payment for such services. Since the last survey RD has visited the facility monthly and as of 04/21/2016, the facility remains current In payment and in good standing with the provider. There has been no suspension or interruption of RD services since the last survey.

RECEIVED
JUN 08 2016