

Division of Health Care Facilities

RECEIVED

FEB 22 2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN4001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2016
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NAME OF PROVIDER OR SUPPLIER BENCHMARK HEALTHCARE OF PURYEAR INC	STREET ADDRESS, CITY, STATE, ZIP CODE 220 COLLEGE STREET PURYEAR, TN 38251
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 615	<p>1200-8-6-.06(2)(d)3. Basic Services</p> <p>(2) Physician Services.</p> <p>(d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall:</p> <p>3. Review reports of all accidents or unusual incidents occurring on the premises, identifying hazards to health and safety and recommending corrective action to the administrator;</p> <p>This Rule is not met as evidenced by: Type C Pending Penalty #24</p> <p>Tennessee Code Annotated 68-11-804(c)24 The nursing home's medical consultant shall review all accidents and unusual incidents occurring on the premises, identify hazards to health and safety, and recommend corrective action to the nursing home administrator.</p> <p>Based on review of Quality Assurance (QA) Committee minutes and sign in sheets and interview, the facility failed to ensure the Medical Director (MD) assisted the facility with identifying and evaluating clinical concerns when the facility failed to follow their fall policy and ensure the MD 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's failure to implement appropriate interventions for falls resulted in actual harm to Residents #6, 24 and 26.</p> <p>The findings included:</p>	N 615	<p>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.</p> <p>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.</p> <p>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.</p>	02/18/16

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bow Lancaster WHA

(X6) DATE

02/19/16

Division of Health Care Facilities

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N 615	<p>Continued From page 1</p> <p>The facility's "Quality Improvement Committee Meeting Attendance Sign-in" sheets dated 11/24/15, 12/17/15, and 1/20/16 revealed the medical director was in attendance.</p> <p>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 4 of those falls resulting in resident injury and documented, "...Above IR [incident review] reviewed/discussed with Medical Director."</p> <p>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."</p> <p>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."</p> <p>Telephone interview with the 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 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</p>	N 615	<p>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.</p>	02/18/16

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N 615	Continued From page 2 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 to have alarms that do not work." The MD was asked if they discussed falls in QA. 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."	N 615	<p>RECEIVED</p> <p>FEB 22 2016</p>	
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