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

1st 4/26/13

PRINTED: 03/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445172		03/12/2013

NAME OF PROVIDER OR SUPPLIER: KINDRED NURSING AND REHABILITATION-SMITH COUNTY

STREET ADDRESS, CITY, STATE, ZIP CODE: 112 HEALTH CARE DR, CARTHAGE, TN 37030

(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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain and enhance the dignity of one resident (#87) of seventeen residents reviewed. The findings included: Resident #87 was admitted to the facility on December 18, 2010, and readmitted to the facility on October 30, 2012, with diagnoses including Edema, Diabetes Mellitus Type 2 without complication, Bipolar Disorder, Ascites, and Atrial Fibrillation. Observation of the resident on March 5, at 12:30 p.m., March 6, at 8:10 a.m., March 7, at 1:15 p.m., and March 11, 2013, at 9:50 a.m, and 3:10 p.m., in the resident's room, revealed a handwritten sign posted on the outside of the resident's closet door which read, "...is not to have briefs on. Use disposable chucks." Interview with the Assistant Director of Nursing (ADON) on March 11, 2012, at 3:35 p.m., in the resident's room, confirmed the posted sign regarding the private care of the resident should not be posted openly in the resident's room.	F 241	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F241 It is the practice of this facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect. The sign noted in Resident #87 room was removed during survey on 03/05/13. An inspection of all resident rooms was conducted on 3/5-6/13 for any additional questionable signage and any found was removed. The DNS, ADNS or SDC will in service the nursing staff and other clinical staff on resident's right to dignity and respect to include the restrictions on posting signs or notices in a resident's room. In-services will be conducted on 4/7/13, 4/8/13, and 4/9/13. Licensed nurses will observe for and if necessary remove inappropriate signage during their routine rounds, medication passes, etc. and report such to the DNS/ADNS. The DNS, ADNS, and /or SDC will make rounds at least 3 days a week for 4 weeks and then weekly thereafter for compliance. Clinical dept manager such as SW, Activity Director, RD and will also be charged with observing for and removing any inappropriate signage and reporting such to the Administrator or DNS. The DNS and/or SSW will report results of	04/26/13
F 247 SS=E	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE	F 247		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 04/04/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 247	Continued From page 1 A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to provide notice of room/roommate change for three (#112, #24, and #17) of seventeen residents reviewed. The findings included: Resident #112 was admitted to the facility on September 25, 2012, with diagnoses including Diabetes Mellitus, Multiple Sclerosis, Depression, and Psychotic Disorder. Medical record review of a quarterly Minimum Data Set (MDS) dated December 12, 2012, revealed the resident scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the resident is cognitively intact. Medical record review of a progress note dated December 24, 2012, revealed the resident received a new roommate on December 24, 2012. Continued review revealed the resident was introduced to the new roommate by the Social Services (SS) Director. Interview with the resident on March 12, 2013, at 9:51 a.m., in the resident's room revealed, "I had a roommate about 2 months ago for 2-3 days, it was too cold in here for (the roommate). Further interview revealed, the resident did not receive	F 247	these rounds and compliance with posting restrictions to the Facility Performance Improvement Committee (QAA) at it regular scheduled meeting for review, discussion and recommendations (if any), for 3 months and then at least quarterly thereafter. The Membership of the PI (QA) Committee is: Medical Dir, Admin, DON, ADON; MDS Coordinator, Staff Development Dir, Directors of: Soc Services; Act; Business Ofc; Dietary Services, Hskg/Laundry, Maintenance, Med Records and PI (QA) Team Leader(s). F247 - It is the practice of the facility to ensure the resident receives notice the resident's room or roommate is changed. Resident #112, #24 and #17 will be informed in advance of any new roommate and /or room change by the facility SSW and such notice documented in the resident's medical record. Every resident residing in the facility will be informed in advance when receiving a new roommate and or room change by the facility SSW. In the absence of the SSW the facility administrator, DNS or ADNS will perform this function. The DNS, ADNS, SDC or SSW will in service all clinical staff on resident's right to advance notice or roommate or room change. In-services will be conducted on 4/7/13, 4/8/13, and 4/9/13. Medical records clerk will audit medical records of residents who received a new roommate or room change each week for the previous week X 4 weeks and then monthly X 3 months and then a 10% sample of room changes /roommate changes each quarter.	4/26/13.

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F 247	Continued From page 2 notice of new roommate, "they just did it...didn't tell me." Resident #24 was admitted to the facility on April 26, 2005, with diagnoses including Cerebrovascular Accident, Right Side Hemiplegia, and Depression. Medical record review of a quarterly MDS dated December 11, 2012, revealed the resident scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the resident is cognitively intact. Medical record review of a progress note dated December 11, 2012, revealed the resident received a new roommate on December 11, 2012. Interview with the Admissions Coordinator on March 11, 2013, at 2:50 p.m., at the nurses' station confirmed the resident had a recent roommate change, "that was before I started doing this, so I don't know any of the details." Interview with the resident on March 12, 2013, at 9:58 a.m., in the resident's room, revealed the resident had a roommate change "three to four months ago...I have lived in three different rooms since I started living here...they didn't tell me I was getting a new roommate...it bothers me when they don't tell me." Resident #17 was admitted to the facility on December 8, 2012, with diagnoses including Fatigue, Congestive Heart Failure, Anxiety, Depression, and Urinary Tract Infection.	F 247	The medical records clerk will submit written reports of these audits to the facility administrator. The Administrator will report results of the audits to the Facility Performance Improvement Committee (QAA) at it regular scheduled meeting for review, discussion and recommendations, if any. The Membership of the PI (QA) Committee is: Medical Dir, Admin, DON, ADON; MDS Coordinator, Staff Development Dir, Directors of: Soc Services; Act; Business Ofc; Dietary Services, Hskg/Laundry, Maintenance, Med Records and PI (QA) Team Leader(s).	

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F 247	Continued From page 3 Medical record review of a quarterly MDS dated February 2, 2013, revealed the resident scored 14 out of 15 on the BIMS, indicating the resident is cognitively intact. Medical record review revealed no documentation of a room/roommate change for this resident. Interview with the Admissions Coordinator on March 11, 2013, at 2:50 p.m., revealed, "(the resident) hasn't had a roommate change that I am aware of." Interview with the resident on March 12, 2013, at 12:32 p.m., in the resident's room revealed, the resident was moved to a different room "about 3 weeks ago...was in a room with (resident) who liked the room to be cool...I like a warmer room...never asked me if I wanted to move, they just moved me." Interview with the Admissions Coordinator on March 11, 2013, at 2:50 p.m., at the nurses' station revealed, the room/roommate change process usually occurs when "the resident may request a room change because of differences in room temperature, etc...take a list of available rooms to the resident and show it to them, may also take the resident to that room and show them the room, so they can see if they like the new room. Normally we chart the room change in the resident's chart under progress notes." Room/roommate changes are usually done by Social Services Director, but "she left at the end of last year and I am just filling in."	F 247		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278	F278 – It is the practice of this facility to ensure assessments on all residents' accurately reflects the resident's status at the time the assessment is conducted.	4/26/13

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F 278	Continued From page 4 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 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 for bladder function, skin and dental status for two (#63, #37) of thirty-seven residents reviewed. The findings included:	F 278	The Minimum Data Set (MDS) on Residents #63 and #37 will be updated to accurately reflect the residents current bladder function, skin and dental status by the MDS assessment nurse by 4/10/13. The DNS, ADNS, SDC, MDS nurses and Care Plan Coordinator will review current residents most recent Minimum Data Set (MDS) to ensure it accurately reflected the resident's status for bladder function, skin and dental at the time it was conducted. Corrections, modifications or significant change assessments identified will be completed by 4/18/13. Licensed nursing staff will be in-serviced on the process of completing assessments that are both accurate and timely by the SDC, DNS and/or ADNS on 4/14/13, 4/15/13, 4/16/13. The DNS and/or ADNS will audit 25% of Minimum Dada Sets (MDS) completed each week for accuracy X 4 weeks and then 10% completed each month X 3 months and then quarterly thereafter. The DNS will report results of the audits to the Facility Performance Improvement Committee (QAA) at it regular scheduled meeting for review, discussion and recommendations, if any. The Membership of the PI (QA) Committee is: Medical Dir, Admin, DON, ADON; MDS Coordinator, Staff Development Dir, Directors of: Soc Services; Act; Business Ofc; Dietary Services, Hskg/Laundry, Maintenance, Med Records and PI (QA) Team Leader(s).	

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F 278	Continued From page 5 Resident #63 was admitted to the facility November 21, 2012, with diagnoses to include Depression, Hypertension, and Urinary Tract Infection. Medical record review of the significant change Minimum Data Set (MDS) assessment dated December 12, 2012, revealed the resident was always incontinent of bowel and bladder, and was on a bladder training program. Review of the comprehensive MDS assessment dated March 3, 2013, revealed the resident was always incontinent of bowel and bladder and was on a bladder training program. Interview with Licensed Practical Nurse (LPN) #2 on March 6, 2013, at 2:20 p.m., in nursing station, revealed resident "...rarely says I have to go to bathroom...". Continued interview revealed the bladder evaluations showed resident was incontinent. Further interview revealed resident is now changed every two hours but is not on a toileting program. Continued interview revealed the resident is very confused; "...I don't think she could be involved in a program...". Interview with the Treatment Nurse, on March 6, 2012, at 2:50 p.m., revealed resident is not completely incontinent. Continued interview revealed resident may put on call light to say she needs to be changed but cannot tell staff ahead of time. Further interview revealed resident underwent significant change in October; was sent to a psych hospital for behavioral issues; and was unable to control urine upon return. Continued interview confirmed the resident had not been on any bladder training program or	F 278		

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F 278	Continued From page 6 toileting program since November 2012. Further interview revealed residents who are incontinent were reassessed every three months so resident would be coming up for reassessment soon. Interview with the MDS Coordinator, on March 6, 2013, at 3:10 p.m., in nursing station, revealed the MDS was not accurate regarding the resident being on a toileting program. Resident #87 was admitted to the facility on December 18, 2010, and readmitted to the facility on October 30, 2012, with diagnoses including Edema, Diabetes Mellitus Type 2 without complication, Bipolar Disorder, Ascites, and Atrial Fibrillation. Medical record review of the quarterly Minimum Data Set (MDS) dated July 25, 2012, revealed documentation of pressure ulcers as one stage 2 pressure ulcer and zero as the number of stage 3 pressure ulcers. Medical record review of the" Weekly Pressure Ulcer...Report" revealed documentation of a stage 3 pressure ulcer for the weeks of June 26, July 5, 10, 17, 24, 31, August 7, 14, 2012. Medical record review of the quarterly MDS dated January 14, 2013, revealed documentation of one stage 2 pressure ulcer and 'zero' as the number of current stage 4 pressure ulcers. Continued review revealed documentation of one worsening pressure ulcer to stage 4. Medical record review of "Weekly Pressure Ulcer... Report" revealed the presence of a stage 4 pressure ulcer with date of first observation as	F 278		

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F 278	Continued From page 7 December 13, 2012. Continued review of "Weekly Pressure Ulcer... Report" revealed the presence of a stage 4 pressure ulcer on the weeks of December 20 and December 27, 2012, and January 3 and January 10, 2013. Medical record review of consulting "Wound Care Specialist Evaluation" dated March 5, 2013, revealed "...patient has a Stage 4 pressure wound of the left, upper buttock of at least 64 days duration..." Continued review of the medical record evaluation revealed " ...Etiology (Quality): Pressure ...MDS 3.0 Stage: 4..." Review of Quarterly MDS dated January 14, 2013, revealed documentation the resident did not have any current oral or dental problems. Medical record review of "Medical Nutrition Therapy Assessment" forms dated September 20, 2012, November 5, 2012, and January 17, 2013, all documented the resident had missing teeth. Observation and interview of the resident on March 5, 2013, at 12:52 p.m., in the resident's room, revealed the resident had several missing teeth in the front and bottom of the resident's mouth. Continued observation and interview with the resident revealed the resident reported several loose teeth and a tooth on bottom right "...that is sharp..." Continued interview with the resident revealed the resident stated: "...my teeth hurt and are really loose...started getting loose and coming out..." Interview with the MDS Coordinator and Case Management Licensed Practical Nurse (LPN) on	F 278		

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F 278	Continued From page 8 March 12, 2013, at 10:30 a.m., in the Classroom, confirmed the pressure ulcer and dental status of the resident was not accurately assessed and documented on the Quarterly MDS dated July 25, 2012, and January 14, 2013.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to develop comprehensive care plans to address urinary incontinence for one (#59) of thirty seven residents reviewed. The findings included:	F 279	F279 – It is the practice of the facility to use the results of the assessment to develop, review and revise the resident's comprehensive care plan. Resident #59 is no longer a resident of this facility. The Interdisciplinary Care Plan Team (IDT) (MDS Coor., Nursing, Nurse Case Manager, RD, SSW, Activity Director), will review the care plans of all residents who are incontinent of bladder for a care plan that addresses their urinary incontinence or as indicated develop an appropriate individualized plan of care to address the residents urinary incontinence. Licensed nursing staff will be in-serviced on the process of initiating and implementing a care plan to address a resident's urinary incontinence by the SDC, DNS and/or ADNS on 4/14/13, 4/15/13, and 4/15/13. The DNS and/or ADNS will audit 25% of Comprehensive Care Plans (CCP) completed each week for appropriate interventions addressing urinary incontinence X 4 weeks and then 10% completed each month X 3 months and then quarterly thereafter. The DNS will report results of the audits to the Facility Performance Improvement Committee (QAA) at it regular scheduled meeting for review, discussion and	4/26/13

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F 279	Continued From page 9 Resident #59 was admitted to the facility on October 18, 2012, with diagnoses including Congestive Heart Failure, Diabetes, Dementia, Recurrent Bilateral Lower Extremity Cellulitis, Atrial Fibrillation, Depression,Psychosis, Neuropathy in Diabetes, Muscle Weakness, Debility, Hypothyroidism, Kidney Disease, Anemia, Osteoarthritis, Hypertension. Medical record review of the Minimum Data Set (MDS) dated January 7, 2013, revealed the resident was cognitively intact for daily decision making, and required extensive assistance from the staff for all activities of daily living except for eating. Continued review revealed the resident was not on a toileting program, and was coded as a "2" indicating the resident was frequently incontinent (7 or more episodes of urinary incontinence, but a least 1 episode of continent voiding). Review of the care plan dated October 31, 2012, revealed no documentation the resident's incontinence was identified as a problem in the care plan. Interview with the resident in resident's room on March 7, 2013, at 8:30 a.m., revealed the resident occasionally felt the "urge" to urinate; and often was unable to control urination. Interview with MDS Coordinator, in MDS office, at 2:15 pm on March 7, 2013, confirmed the facility failed to develop a plan of care for urinary incontinence.	F 279	recommendations, if any. The Membership of the PI (QA) Committee is: Medical Dir, Admin, DON, ADON; MDS Coordinator, Staff Development Dir, Directors of: Soc Services; Act; Business Ofc; Dietary Services, Hskg/Laundry, Maintenance, Med Records and PI (QA) Team Leader(s).	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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F 280	Continued From page 10 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 medical record review and interview the facility failed to include one resident (#87) in Care Plan meetings, of thirty-seven residents reviewed. The findings included: Resident #87 was admitted to the facility on December 18, 2010, and readmitted to the facility on October 30, 2012, with diagnoses including Edema, Diabetes Mellitus Type 2 without complication, Bipolar Disorder, Ascites, and Atrial Fibrillation.	F 280	F280 – It is the practice of this facility to invite and include each resident in their individual Care Plan Meeting. The Interdisciplinary Care Plan Team (IDT) will at Resident #87 request conduct an individual care plan meetings with resident #87 in his room in private and document such in the medical record. The SSW will give each resident advanced notice and invitation to their individual care plan meeting. On the day of the residents' care plan a member of the IDT will remind resident of the meeting and include residents' specific accommodation request. The invitation and attendance (or lack of) will be documented in the residents' medical record to include residents' signature or mark if unable to write. The DNS, ADNS, SDC or SSW will in service all clinical staff on resident's right to attend their individual care plan meeting with/without special accommodation or request. In-services will be conducted on 4/7/13, 4/8/13, and 4/9/13. Medical records clerk will audit 25% of medical records on residents with a scheduled care plan meeting for documentation of invitation/attendance each week for the previous week X 4 weeks and then 10%monthly X 3 months and then a the quarterly thereafter. The medical records clerk will submit written reports of these audits to the facility administrator. The Administrator will report results of the audits to the Facility Performance Improvement Committee (QAA) at it regular scheduled meeting for review, discussion and recommendations, if any.	4/26/13

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F 280	Continued From page 11 Medical record review of the Minimum Data Set (MDS) Significant change assessment dated November 6, 2012, revealed the resident scored a 15 on the Brief Interview of Mental Status (BIMS), which indicated the resident was cognitively intact. Medical record review of the MDS Significant change assessment dated January 14, 2013, revealed the resident scored a 12 on the BIMS indicating the resident had some moderate impairment in memory and decision making skills. Review of the resident's care plan dated November 15, 2012, revealed "...Problem description...Activity deficit...related to...does not attend group activities..." Interview with the resident on March 7, 2013, at 1:15 p.m., in the resident's room, revealed the resident did not remember being invited to attend and participate in the resident's Care Plan meetings. Continued interview with the resident revealed the resident was unable to read "...so sometimes I avoid things in which I may have to read..." Interview with the resident on March 11, 2013, at 10:00 a.m., in the resident's room, revealed no staff member had offered to hold a Care Plan meeting in the resident's room. Continued interview revealed the resident "...does not like to go out of his room because I have difficulty with large groups..." Interview with the Minimum Data Set (MDS) Coordinator and Case Management Licensed	F 280	The Membership of the PI (QA) Committee is: Medical Dir, Admin, DON, ADON; MDS Coordinator, Staff Development Dir, Directors of: Soc Services; Act; Business Ofc; Dietary Services, Hskg/Laundry, Maintenance, Med Records and PI (QA) Team Leader(s).	

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F 280	Continued From page 12 Practical Nurse (LPN) on March 12, 2013, at 10:30 a.m., in the Classroom, revealed that both the MDS Coordinator and Case Management LPN were aware the resident was unable to read and write. Continued interview revealed the process for inviting the resident to Care Plan meetings is by a letter given to the resident by the Social Worker informing the resident of the date and time of the meeting. Further interview confirmed the MDS Coordinator and the Case Management LPN had not invited the resident through verbal invitation, or offered the resident the opportunity to hold Care Plan meetings in the resident's room, and confirmed the resident had never attended a Care Plan meeting.	F 280		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to put interventions into place to prevent decline in bladder function for two (#59, #63), of thirty seven residents reviewed.	F 315	F315 It is the practice of the facility to ensure a resident who is incontinent of bladder receives appropriate treatment and services to restore as much normal bladder function as possible. Resident #59 has been discharged from the facility. Resident #63 has been reassessed to determine current voiding pattern and an individualized bladder program in place on 4/4/13. On all incontinent residents the current MDS will be compared with the previous MDS to determine if a change in level of incontinence has occurred. Residents who have exhibited a change to occasionally or frequently incontinent will have a bladder evaluation completed and the appropriate toileting/incontinent program care planned and implemented. Residents with urinary incontinence will be assessed on admission, with significant change in continence status and reviewed at least annually. These assessments will be reviewed at the daily weekday clinical meeting held by the DON, ADON, RN Shift Supervisor for completeness, accuracy and initiation of appropriate care plan interventions. Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator to	04/26/13

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F 315	Continued From page 13 The findings included: Resident #63 was admitted to the facility on November 21, 2012, with diagnoses to include Depression, Hypertension, and Urinary Tract Infection. Medical record review of a significant change Minimum Data Set (MDS) dated December 12, 2012, revealed the resident was always incontinent of bowel and bladder. Continued medical record review revealed revealed a comprehensive MDS assessment dated March 3, 2013, which revealed the resident was always incontinent of bowel and bladder. Review of Care Conference notes dated November 6, 2012, revealed "...incontinent of bowel and bladder, on prompted voiding program...". Review of the Patient Nursing Evaluation dated November 21, 2012, revealed resident was occasionally incontinent of bladder and always continent of bowel. Review of the care plan dated November 13, 2012, with a review date of March 17, 2013, addressed a problem of skin integrity due to incontinence of bowel and bladder with interventions including: 1. check for incontinence Q2H & prn; provide pericare after each episode of incontinence 2. assist resident with toileting as needed 3. follow prompted/habit toilet program Review of a Bladder Voiding Pattern Record dated October 23 - 25, 2012, revealed the	F 315	in-service all licensed nurses on the Bladder evaluation and process 4/14/13, 4/15/13, and 4/16/13. Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator to in-service the certified nursing techs (CNT's) on the Bladder evaluation and process 4/14/13, 4/15/13, and 4/16/13. The DNS and/or ADNS will audit 25% of all admission assessments and MDS completed, to include care plan implementation and documentation of interventions effectiveness each week from prior week X 4 weeks; then audited monthly for three (3) months and then at least quarterly thereafter. DNS will report results of the audits to Performance Improvement Committee monthly for review, discussion and recommendations. The Membership of the PI (QA) Committee is: Medical Dir, Admin, DON, ADON; MDS Coordinator, Staff Development Dir, Directors of: Soc Services; Act; Business Ofc; Dietary Services, Hskg/Laundry, Maintenance, Med Records and PI (QA) Team Leader(s). The Administrator is responsible for overall compliance.	

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F 315	Continued From page 14 resident was checked 51 times; was wet 23 times; dry 28 times; was toileted 9 times; and voided 24 times. Review of a Bladder Voiding Pattern dated October 28- 30, 2012, revealed the resident was checked 24 times; was wet 10 times; was dry 13 times; was toileted 8 times; and voided 12 times. Review of a Bladder Voiding Pattern Record dated November 22 - 24, 2012, revealed the resident was checked 20 times; was wet 9 times; was dry 11 times; was toileted 3 times; and voided 2 times. Review of a Bladder Voiding Pattern Record dated January 3 - 5, 2013, revealed resident was checked 30 times over the three days. Continued review revealed the resident was found to be wet on 21 occasions and dry on 9 occasions. Further review revealed the resident was toileted six times and voided 12 times., Interview with Licensed Practical Nurse #2 on March 6, 2013, at 2:20 p.m., in nursing station, revealed resident "...rarely says I have to go to bathroom...". Continued interview revealed the bladder evaluations showed resident was incontinent. Further interview revealed resident is now changed every two hours but is not on a toileting program. Continued interview revealed the resident is very confused; "...I don't think she could be involved in a program...". Interview with the Treatment Nurse, on March 6, 2012, at 2:50 p.m., revealed resident is not completely incontinent. Continued interview revealed resident may put on call light to say she	F 315		

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F 315	Continued From page 15 needs to be changed but cannot tell staff ahead of time. Further interview revealed resident underwent significant change in October; was sent to a psych hospital for behavioral issues; and was unable to control urine upon return. Continued interview confirmed the resident had not been on any bladder training program or toileting program since November 2012. Further interview revealed residents who are incontinent were reassessed every three months so resident would be coming up for reassessment soon. Interview with the MDS Coordinator, on March 6, 2013 at 3:10 p.m., in the nursing station, confirmed the faci;lity had not provided a continuous toileting program to maintain bladder function. Resident #59 was admitted to the facility on October 18, 2012, with diagnoses including Congestive Heart Failure, Diabetes, Dementia, recurrent Bilateral Lower Extremity Cellulitis, Atrial Fibrillation, Depression,Psychosis, Neuropathy in Diabetes, Muscle Weakness, Debility, Hypothyroidism, Kidney Disease, Anemia, Osteoarthritis, and Hypertension. Medical record review of the Minimum Data Set (MDS) dated October 18, 2012, revealed the resident was cognitively intact for daily decision making. Continued review revealed, the resident required extensive assistance from the staff for all activities of daily living except for eating. Continued review revealed the resident was not on a toileting program, and was coded as a "2" indicating the resident was frequently incontinent (7 or more episodes of urinary incontinence, but at least 1 episode of continent voiding).	F 315		

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F 315	Continued From page 16 Review of the facility policy, , titled "Bladder Status Evaluation included instructions to "Obtain a baseline voiding record to determine if urine output is excessive or inadequate for 3 days..." Review of the Bladder Status Evaluation for resident #59 dated November 26, 2012, revealed the resident was continent of bladder. Medical record review of the Minimum Data Set (MDS) dated January 7, 2013, revealed the resident was not on a toileting program, and was coded as a "3" indicating the resident is always incontinent (no episodes of continent voiding). Review of the Care Plan dated February 1, 2011, and updated February 10, 2013, for the identified issue of Skin Integrity, revealed interventions including "Provide adult briefs as needed...turn and reposition Q 2 hrs and PRN..." Interview with the resident in the resident's room on March 7, 2013, at 8:30 a.m., revealed the resident occasionally felt the "urge" to urinate..."but I still just 'go' in my diaper." Interview with the MDS Coordinator, in the MDS office, at 2:15 p.m., on March 7, 2013, verified the resident had a decline in bladder function from October 2012 to January 2013; and confirmed the facility failed to put interventions in place to prevent the decline.	F 315		
F 323 SS=D	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	F 323		

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F 323	Continued From page 17 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility investigations, review of facility documentation and interview, the facility failed to implement an intervention to prevent future falls and failed to ensure interventions in place were properly functioning to prevent future falls for one resident (#34) and failed to provide an environment free of accidents, and failed to complete an accurate falls investigation for one resident (#140) of thirty-seven residents reviewed. The findings included: Resident #34 was admitted to the facility April 1, 2011, and readmitted to the facility on March 23, 2012, with diagnoses including Personal History of Falls, Fracture Multiple Ribs, Diabetes Mellitus Type 2 without Complication, Senile Dementia, Reactive Confusion, Anxiety State NOS (not otherwise specified), Depressive Disorder, Alzheimer's Disease, and Weakness. Medical record review of the quarterly Minimum Data Set (MDS) dated January 15, 2013, revealed the resident had severely impaired cognition and required extensive assistance with all activities of daily living. Medical record review of the resident's Care Plan	F 323	F323 It is the practice of this facility to ensure the residents environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistive devices to prevent accidents.. Resident #34 and Resident #140 the care plan interventions to reduce risk of falls have been reviewed and if indicated updated by the Interdisciplinary Care Plan Team (IDT) and communicated to the nursing staff. Alarm device(s) in use will be checked for placement & operation each shift by the licensed nurse and documented. The IDT will review all residents with a fall in last 30 days to ensure an investigation has been completed, care plan updated, interventions communicated to nursing staff and are in place. The DNS, ADNS, or SDC will in service nursing staff on facility fall prevention program. In-services will be conducted on 4/14/13, 4/15/13, and 4/16/13. A master list of fall prevention devices including alarms will be maintained by the facility Falls Prevention Champion. Alarms to be monitored for placement and operation each shift by licensed nurses and documented. Alarms / batteries to be tested weekly and documented by Central Supply Clerk. All admissions, readmissions and new falls	4/26/13

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F 323	Continued From page 18 dated January 23, 2013, revealed the resident was at risk for falls "...as evidenced by falls prior to admission, requires assistance with transfers and ambulation..." Continued review of the resident's Care Plan dated April 10, 2012, revealed the following interventions to prevent future falls "...pressure alarm to chair and bed...Q (every) 30 min (minute) checks while in bed...Infared alarm to bed..." Review of facility documentation revealed the resident had twelve separate falls between April 14, 2012, and February 3, 2013. Review of facility documentation, "Fall Checklist" form, not dated, revealed the resident had a fall without injury on September 9, 2012, "...resident noted to be sitting on buttocks on floor mat next to bed..." Continued review of "Fall Checklist" revealed "...Intervention for Root Cause...Q 30 min checks while in bed..." Review of facility documentation, "Fall Checklist" form, not dated, revealed the resident had a fall without injury on December 3, 2012, "...resident rolled out of bed onto mat..." Further review of the form revealed "...could not hear alarm. Roomate had closed door..." Continued review of "Fall Checklist" revealed "Intervention for Root Cause...Infra red alarm to bed..." Review of facility documentation, "Fall Checklist" form, not dated, revealed the resident had a fall without injury on December 7, 2012, "...resident noted to be on floor mat next to bed..." Continued review of facility documentation, "Post Fall Evaluation" form, dated December 7, 2012, revealed "...resident found on floor on	F 323	will be reviewed in the weekday Clinical Rounds Meeting (DNS, ADNS, SDC, RN Sup'r, SSW) will review the incident, complete investigation, concur with new interventions implemented and/or make additional revisions, update care plan and communicate changes/updates to nursing staff. Fall Prevention Committee (DNS, ADNS, RN Sup'r, SDC) to meet weekly to review residents with falls in past 7 days to include the investigation, as well as new admissions who were identified at risk for falls to review care plan for effectiveness of fall prevention interventions and if indicated make revisions. The Fall Prevention Committee will track and trend falls and the DNS will present its findings to the facility Performance Improvement, Committee each month for review, discussion and recommendations, if indicated The Membership of the PI (QA) Committee is: Medical Dir, Admin, DON, ADON; MDS Coordinator, Staff Development Dir, Directors of: Soc Services; Act; Business Ofc; Dietary Services, Hskg/Laundry, Maintenance, Med Records and PI (QA) Team Leader(s). The Administrator is responsible for overall compliance.	

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F 323	Continued From page 19 mat...alarms-bed didn't go off nor the infer (infra) red-which was turned off..." Review of facility documentation, "Fall Checklist" form, not dated, revealed the resident had a fall without injury on December 15, 2012, "...resident noted to be sitting on floor mat next to bed. Resident had slid off of bed..." Continued review of facility documentation, "Tracking Record for Improving Patient Safety" form, dated December 15, 2012, revealed an "x" mark in box " (indicating)...bed alarm did not sound during event...slid off bed with resident..." Interview with the Director of Nursing (DON) on March 12, 2013, at 9:10 a.m., in the Classroom, confirmed the facility had no documentation for performing every thirty minute checks for the resident after the fall on September 9, 2012. Continued interview with the DON, at that time, confirmed the pressure pad bed alarm and infrared alarm were not properly applied or functioning at the time of the resident's fall on December 7, 2012. Further interview with the DON, at that time, confirmed the pressure pad bed alarm did not sound at the time of the resident's fall on December 15, 2012. Resident #140 was admitted to the facility on February 22, 2013, with diagnoses including Subscapular Fracture with Open Reduction Internal Fixation Secondary to Fall, Type 2 Diabetes Mellitus, Dementia, and Arthritis. Medical record review of an History and Physical (H&P) received from the previous facility at admission dated February 19, 2013, revealed "...fall risk..."	F 323		

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F 323	Continued From page 20 Medical record review of the "Patient Nursing Evaluation" dated February 23, 2013, revealed "Morse Fall Risk Scale...risk score of 50...(scale lists) high risk=45 and Higher...refer to...Morse Fall Risk Interventions. Add risk factors for fall to the care plan. Refer to Falling Star Program..." Medical record review of the "Fall Care Plan" dated February 23, 2013, revealed interventions of "...use fall risk screen to identify risk factors...institute falling star program...report falls to physician and responsible party...appropriate footwear...provide resident/family teaching to include: safety measures to reduce fall risk ..." Medical record review of the "Resident Progress Notes" dated February 24, 2013, at 3:30 p.m., revealed "...transfers /c (with) standby assist to wc (wheelchair) ambulation /c 4 prong cane /c standby assist and/or independent...continues on fall precautions..." Continued review of progress notes dated February 24, 2013, at 8:00 p.m, "....assisted pt (patient) to br (bathroom) ambulated well /c assist x (times) 1 (person)...became slightly unsteady ambulating back to bed..." Further review of progress notes dated March 1, 2013, at 11:15 p.m., "...resident found lying in floor of (another resident room) at foot of bed...stated did not know how fell and 'I was trying to find someone to talk to'...wearing heel protectors over nonskid socks...no injury evident...dr (doctor)...called...vm (voice mail) referred to (hospital Emergency Room)...s/w (spoke with) m (Registered Nurse) @ (at) er (Emergency Room) who stated if no injury call dr. in am...family contacted...t/c (telephone call) son...bed alarm applied and activated..."	F 323		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445172		03/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-SMITH COUNTY	112 HEALTH CARE DR CARTHAGE, TN 37030

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F 323	Continued From page 21 Medical record review of the "Falls Care Plan" dated March 2, 2013, revealed "...fall interventions...bed alarm..." and March 4, 2013, revealed "...fall intervention...use heels up cushion...no heel protectors..." Medical record review of the "Post Fall Evaluation" dated March 4, 2013, revealed "...interventions in place at time of fall...alarm...low bed...call bell in place...footwear/assistive devices at time of fall...socks...summary of interdisciplinary team...rehab caseload, bed alarm, utilize heels up cushion in lieu of heel protection..." Observation on March 6, 2013, at 8:10 a.m., revealed the resident in the bed, no heel protectors, room clear of obstacles in floor and falling star magnet on the door facing outside of room. Interview on March 11, 2013, at 3:10 p.m., in the nursing station with the Assistant Director of Nursing (ADON), revealed the "Morse Fall Risk Interventions" was a "guideline" for interventions. Safety intervention was "...consider patient safety alarm (tab alarm and/or pressure sensor alarm)...yes for high risk..." Review of the "Supervisor Investigation and Root Cause Analysis of Fall" form and interview with the ADON in the dining/activity room on March 12, 2013, at 9:18 a.m., confirmed the bed alarm was not in place at time of the fall as indicated on the post fall assessment form "...bed alarm intervention put in place and 'foam cushions' removed...". ADON further stated the Morse Fall	F 323		

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F 323	Continued From page 22 Scale is used to "consider bed alarm if high risk...resident was admitted ambulatory so the bed alarm wasn't felt to be needed."	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide sanitary storage of prepared food trays for two (#600 hallway and #700 hallway) of six hallways, failed to prevent visitor access to the one of one resident nutrition rooms, and failed to maintain proper refrigerator temperature in one of one resident nutrition refrigerators surveyed. The findings included: Observation on March 6, 2013, at 5:37 p.m., in the 600 hallway revealed, supper trays delivered by the dietary department in a rolling cart. Continued observation, at that time, revealed resident #75's family member #2 and resident #50's family member #3 retrieving a supper tray from the rolling cart. Observation on March 11, 2013, at 10:59 a.m., in	F 371	F371 – It is the practice of the facility to store, prepare, distribute and serve food under sanitary conditions. The facility administrator will take a number of steps provide sanitary storage of prepared food to include a) key to the resident pantry has been relocated to a more secure location, b) Signs will be added to food carts and resident pantry as staff access only areas, c) a flyer with information explaining the need to restrict access to food carts and pantry will be mailed to each resident's responsible party, d)Activity Director will present in the next Resident Council meeting e)in-service nursing staff on need/reason to limit access to food carts and food pantry and their responsibility to monitor and intervene as needed on 4/7/13, 4/8/13, and 4/9/13. The Maintenance Director had the thermostat adjusted by a HVAC tech and the pantry refrigerator log has reflected temperatures in correct range since. Dietary staff were in-serviced on proper temperature ranges and procedure to follow if not in allowable range by the dietary manager on 3/12/13, 4/2/13, 4/17/13 and 4/18/13. The facility administrator and management team & weekend duty managers to include but not limited to DNS, DNS, SDC,AD, SSW, CM, MDS Nurse, AC, BOM, will conduct observations during meals at various	4/26/13

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F 371	Continued From page 23 the 700 hallway revealed, lunch trays delivered by the dietary department in a rolling cart. Continued observation, at that time, revealed a visitor approached the cart and removed a tray for a resident. Continued observation revealed no staff members around the cart or in the hallway. Further observation at 11:30 a.m., revealed the same visitor came out of the resident's room, went to the nursing station, removed the nutrition room key from behind the glass partition at the nursing station, entered the nutrition room, left the nutrition room, and then replaced the key behind the glass partition at the nursing station. Observation on March 11, 2013, at 11:48 a.m., in the 600 hallway revealed, lunch trays delivered by the dietary department in a rolling cart. Continued observation revealed resident #37's family member #4 retrieving a lunch tray from the rolling cart at 11:55 a.m. Review of the facility's Upstair Refrigerator/Freezer Temperature Log (Refrigerator was circled to indicate the log represented the temperatures of the refrigerator) revealed documentation of the temperatures for January, February, and March 2013. Review of the log revealed instructions to "Record temperatures am (morning) and pm (evening) in the appropriate column...(and guidelines) Refrigerator Temperature: 34-38 F. If temperatures are not at appropriate levels, notify supervisor." Review of the January 2013, recorded temperatures revealed 14 temperatures	F 371	days and times that will include all meal services to monitor for ongoing compliance and intervention if indicated. The Administrator will report results of these to the Facility Performance Improvement Committee (QAA) at it regular scheduled meeting for review, discussion and recommendations, if any. The Membership of the PI (QA) Committee is: Medical Dir, Admin, DON, ADON; MDS Coordinator, Staff Development Dir, Directors of: Soc Services; Act; Business Ofc; Dietary Services, Hskg/Laundry, Maintenance, Med Records and PI (QA) Team Leader(s).	

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F 371	Continued From page 24 documented at 40 degrees F, continued review of the February 2013, recorded temperatures revealed 7 temperatures documented at 40 degrees F, and further review of the temperature from March 1-11, 2013, revealed 3 recorded temperatures documented at 40 degrees F. Interview with the Dietary Manager on March 11, 2013, at 5:10 p.m., in the nutrition room, confirmed the temperatures documented were out of an acceptable range, the supervisor had not been notified of the out of range temperatures, and the facility failed to maintain acceptable temperatures in the resident nutrition refrigerator. Interview with the Assistant Director of Nursing (ADON) on March 11, 2013, at 3:10 p.m., nurses' station revealed, visitors are not allowed to remove and pass trays to the residents. Further interview revealed visitors are not allowed to go into the nutrition room due to "infection control" issues.	F 371		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced	F 412	F412 – The facility does provide from an outside source dental services to meet the needs of each resident. Resident #87 was seen by the dentist and treatment completed on 3/28/13. Dentist has seen and continues to see additional residents rendering dental services as dentist deems necessary. Licensed nurses will by oral assessment and/or interview identify residents who may require or request dental services. These residents will be referred to the dentist for further dental evaluation and if indicated treatment after appropriate consents obtained. This will be completed by 4/12/13. Social Services will maintain a log of who has received dental services, who requires consents for treatment, who is scheduled for treatment, and follow-up appointments as required. Licensed nurses will conduct oral/dental assessments on admission, at least yearly and as needed and notify Social Services if need for referral to dentist indicated. New admissions dental/oral assessment and the 24hr nursing report will be reviewed during weekday Clinical Rounds by DNS, ADNS, SDC, MDS nurses, CM, SSW, for identification of residents with dental needs and timely referral. Social Services will log referral for tracking and follow-up.	4/26/13

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F 412	Continued From page 25 by: Based on observation, medical record review, review of facility documentation and interview, the facility failed to obtain dental services for one resident (#87) of 37residents reviewed. The findings included: Resident #87 was admitted to the facility on December 18, 2010, and readmitted to the facility on October 30, 2012, with diagnoses including Edema, Diabetes Mellitus Type 2 without complication, Bipolar Disorder, Ascites, and Atrial Fibrillation. Medical record review of the Minimum Data Set (MDS) Significant change assessment dated November 6, 2012, revealed the resident scored a 15 on the Brief Interview of Mental Status (BIMS), which indicated the resident was cognitively intact. Medical record review of the MDS Significant change assessment dated January 14, 2013, revealed the resident scored a 12 on the BIMS indicating the resident had some moderate impairment in memory and decision making skills. Medical record review of "Medical Nutrition Therapy Assessment" forms dated September 20, 2012, November 5, 2012, and January 17, 2013, all documented the resident had missing teeth. Medical record review of monthly recapitulation orders dated and signed for March, 2013, revealed "...may have dental consult as	F 412	Licensed nursing staff will be in-serviced on the process of completing oral / dental assessments that are both accurate and timely by the SDC, DNS and/or ADNS on 4/14/13, 4/15/13, and 4/16/13. The DNS and/or ADNS will audit 25% of Minimum Dada Sets (MDS) completed each week for accuracy of dental/oral assessment X 4 weeks and then 10% completed each month X 3 months and then quarterly thereafter. The DNS will report results of the audits to the Facility Performance Improvement Committee (QAA) at it regular scheduled meeting for review, discussion and recommendations, if any. The SSW/Nurse Mgmt will monitor and report the Facility Performance Committee (QAA)on dental services provided that may include how many residents received services, timeliness of dental services rendered, results and any issues identified for review and discussion with or without recommendations The Membership of the PI (QA) Committee is: Medical Dir, Admin, DON, ADON; MDS Coordinator, Staff Development Dir, Directors of: Soc Services; Act; Business Ofc; Dietary Services, Hskg/Laundry, Maintenance, Med Records and PI (QA) Team Leader(s).	

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F 412	Continued From page 26 needed..." Medical record review of the resident's chart revealed no documentation the resident had been seen by a dentist. Observation and interview of the resident on March 5, 2013, at 12:52 p.m., in the resident's room, revealed the resident had several missing teeth in the front and bottom of the resident's mouth. Continued observation and interview with the resident revealed the resident reported several loose teeth and a tooth on bottom right "...that is sharp..." Continued interview with the resident revealed the resident stated "...my teeth hurt and are really loose...started getting loose and coming out..." Interview with the resident on March 7, 2013, at 1:15 p.m., in the resident's room, revealed the resident stated had seen a dentist "...7 to 8 months ago...", however does not remember having had x-rays or any treatment by a dentist at that time, and stated had asked the facility to see a dentist since that time. Interview with the Staffing Coordinator March 7, 2013, in the Staffing Coordinator's office, revealed the Staffing Coordinator had given consent forms to be signed by the resident to floor nurses to obtain signatures from residents for consent to be seen by the dentist. Continued interview with the Staffing Coordinator revealed the resident had not signed the consent form and therefore had not been seen by the dentist. Further interview revealed the Staffing Coordinator had not followed-up on the reason for the resident not signing the consent form and had	F 412		

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F 412	Continued From page 27 not attempted again since the initial attempt of obtaining consent in January, 2013. Continued interview confirmed the Staffing Coordinator was aware the resident was unable to read and write and confirmed may be the reason for the resident's refusal to sign the consent form. Interview with the resident on March 11, 2013, at 3:10 p.m., in the resident's room, revealed "...I may not have signed anything because I did not know where I was for a while..." Continued interview with the resident confirmed the resident does not remember being asked to sign a consent form, and the resident stated may not have signed the consent form because the resident was not able to understand what the consent was because the resident was unable to read and write. Interview with the Staffing Coordinator on March 12, 2013, at 7:55 a.m., in the Dining Room, confirmed the resident had not been seen by the dentist. Continued interview revealed Staffing Coordinator had consent for dental services signed by the resident during the survey.	F 412		
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.	F 431		

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F 431	Continued From page 28 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 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 observation and interview, the facility failed to store resident medications appropriately for one (#52) of forty residents reviewed. The findings included: Observation on March 5, 2013, at 8:15 a.m., of room 601 revealed two residents, one in A bed and one in C bed. On the overbed table of the resident in A bed were two medications:	F 431	F431- It is the practice of the facility to ensure safe and proper storage of residents' medications. The licensed nurse who left medication at the bedside in residents' room has received written counseling and re-education on the safe and proper storage of medication from the DNS on 3/5/13. All licensed nurses will receive addition education on the safe and proper storage of medication on 4/7/13, 4/8/13, and 4/9/13 by the SDC, DNS or ADNS. The nursing management team (DNS, ADNS, SDC, CM, MDS nurses) will conduct rounds at various times of the day that coincide with medication passes or shortly thereafter to observe for presence/ absence of medications left in resident rooms. These rounds will be conducted at least 3 times a week at different medication pass times X 4 weeks, then at least weekly X 3 months and then monthly. The DNS will report results of these rounds to the Facility Performance Improvement Committee (QAA) at it regular scheduled meeting for review, discussion and recommendations, if any. The Membership of the PI (QA) Committee is: Medical Dir, Admin, DON, ADON; MDS Coordinator, Staff Development Dir, Directors of: Soc Services; Act; Business	4/26/13

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F 431	Continued From page 29 Fluticasone Propionate nasal spray 50 mcg and Artificial Tears, both labeled with the name of the resident in bed C. Interview on March 5, 2013, at 8:23 a.m.,in the resident's room, with the Director of Nursing, verified the medications belonging to the resident in bed C were found on the overbed table of the resident in bed A; and confirmed the facility failed to ensure safe and proper storage of the medication.	F 431	Ofc; Dietary Services, Hskg/Laundry, Maintenance, Med Records and PI (QA) Team Leader(s).	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441	F441 – It is the practice of the facility to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The facility administrator will take a number of steps provide sanitary storage of prepared food to include a) key to the resident pantry has been relocated to a more secure location, b) Signs will be added to food carts and resident pantry as staff access only areas, c) a flyer with information explaining the need to restrict access to food carts and pantry will be mailed to each resident's responsible party, d)Activity Director will present in the next Resident Council meeting e)in-service nursing staff on need/reason to limit access to food carts and food pantry and their responsibility to monitor and intervene as needed on process 4/7/13, 4/8/13, and 4/9/13. The facility administrator and management team & weekend duty managers to include but not limited to DNS, DNS, SDC,AD, SSW, CM, MDS Nurse, AC, BOM, will conduct observations during meals at various days and times that will include all meal services to monitor for ongoing compliance and intervention if indicated. The Administrator will report results of these to the Facility Performance Improvement	4/26/13

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F 441	Continued From page 30 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure resident food trays were not accessible to non-employees visiting the facility for two (#600 hallway and #700 hallway) of six hallways and one of one resident nutrition rooms. The findings included: Observation on March 6, 2013, at 5:37 p.m., in the 600 hallway revealed, supper trays were delivered by the dietary department in a rolling cart. Continued observation revealed resident #75's family member and resident #60's family member retrieved a supper tray from the rolling cart. Observation on March 11, 2013 at 10:59 a.m., of the 700 hall revealed lunch trays delivered in a rolling cart by the dietary department . At 11:01 a.m., a visitor approached the rolling cart and removed the tray for a resident, observation revealed no staff members around the rolling cart or on the hallway. At 11:19 a.m., a Certified Nursing Tech #1 (CNT) came from the 600 hall,	F 441	Committee (QAA) at it regular scheduled meeting for review, discussion and recommendations, if any. The Membership of the PI (QA) Committee is: Medical Dir, Admin, DON, ADON; MDS Coordinator, Staff Development Dir, Directors of: Soc Services; Act; Business Ofc; Dietary Services, Hskg/Laundry, Maintenance, Med Records and PI (QA) Team Leader(s).	

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KINDRED NURSING AND REHABILITATION-SMITH COUNTY	112 HEALTH CARE DR CARTHAGE, TN 37030

(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 441	Continued From page 31 and started passing trays. At 11:27 a.m., CNT #1 finished passing the last tray. At 11:30 a.m., the same visitor came out of the resident's room; went to the nursing station; removed the nutrition room key from behind the glass partition around the nursing station; unlocked and entered the nutrition room; left the nutrition room; and replaced the key behind the glass partition in the nursing station. Observation on March 11, 2013, at 11:48 a.m., in the 600 hallway revealed, lunch trays were delivered by the dietary department in a rolling cart. Continued observation revealed resident #37's family member #4 retrieved a lunch tray from the rolling cart at 11:55 a.m. Interview with the Assistant Director of Nursing (ADON) and Treatment Nurse, on March 11, 2013, at 3:10 p.m., in the nursing station, revealed visitors are not allowed to remove and pass the trays from the rolling cart to the residents. Further interview revealed visitors are not allowed to go into the nutrition room due to "infection control" issues. Continued interview confirmed the facility failed to ensure infection prevention procedures were followed.	F 441		