STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **445137**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **09/26/2013**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVINGCENTER - SPRINGFIELD	**104 WATSON ROAD SPRINGFIELD, TN 37172**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0151	**Honor all of the resident's rights as a resident of the nursing home, free of coercion and reprisal, and as a citizen or resident of the United States.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, review of the facility's smoking schedule, medical record review and interview, it was determined the facility failed to honor resident rights to smoke for 3 of 5 (Random Resident (RR) #2, 3 and 4) interviewable random residents that smoke. This finding was related to a substantiated allegation in a complaint investigation initiated on 9/10/13. The findings included: 1. Review of the facility's Smoking Policy documented, .Every resident who desires to smoke is permitted to do so if the center's interdisciplinary team has determined that the practice would be safe for the resident. 2. Review of the facility's SMOKING SCHEDULE DATED 7/25/13 documented, .9:00 A (AM), 10:30 A, 1:30 P (PM), 4:00 P, 7:00 P, 9:00 P. with the persons or department responsibility listed for each smoke time. 3. Medical record review for RR #2 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the nurses CLINICAL HEALTH STATUS dated 9/6/13 documented RR #2's short term and long term memory was marked as .OK (okay) .Additional notes. She was oriented to room and surroundings; instructed to call for assistance as needed. During an interview in RR #2's room on 9/10/13 at 7:35 PM, RR #2 confirmed that she does smoke but she is unable to walk and is dependent on staff to get her out of the bed. RR #2 stated, .smoke time was 7 PM, I turned my light on for them to come to get me up so I could go smoke. I can't walk, I broke my hip. RR #2 was asked how her light got turned off. RR #2 stated, I cut my light on at 6:45 PM (for the 7:00 PM smoke time) and no one came. My light was turned off right before you came in. They finally came in here and got me off the bed into the wheelchair (wc) but I missed the smoke break. During an interview in the conference room on 9/10/13 at 3:00 PM, the Administrator confirmed that residents were allowed to smoke. The Administrator stated, It's their right. During an interview in the conference room on 9/10/13 at 4:30 PM, the Social Worker was asked who is responsible for coordinating the smoke breaks for the residents. The Social Worker stated, Smoke breaks are coordinated by the Director of Nursing and the Administrator. We know ahead of time who is in charge of taking the residents out to smoke. During an interview in the 600 hall on 9/11/13 at 8:05 AM, Certified Nursing Assistant (CNA) #1 was asked if RR #2 could get up by herself. CNA #1 stated, No, she has to have help. She has a [MEDICAL CONDITION] During an interview in the east hall on 9/11/13 at 8:30 AM, CNA #2 was asked who is responsible for getting residents up so they can go out for smoke break. CNA #2 stated, It's ours, its the CNAs. 4. Medical record review for RR #3 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) Brief Interview for Mental Status (BIMS) dated 6/20/13 documented a score of 15 out of 15 indicating RR #3 is cognitively intact. Upon further review of the MDS, it was also documented that it is very important. for RR #3 to go outside to get fresh air when the weather is good. Review of the care plan dated 11/29/10 documented, .Smokes independently with supervision. Assist to and from Designated Smoking Area. During an interview in the 300 hall on 9/10/13 at 7:20 PM, RR #3 was asked if she receives help to get out of the bed when help is needed. RR #3 stated, .a couple of months ago went to bed before 9:00 (PM) smoke break and they wouldn't get me back up, so I just stay up in the wc from the time I get up until after smoke break. If I have to pee they come and change me. They have to use a standing lift to get me up. 5. Medical record review for RR #4 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the MDS Brief Interview for Mental Status dated 5/24/13 documented a score of 15 out of 15 indicating RR #4 is cognitively intact. Upon further review of the MDS, it was also documented that it is very important. for RR #4 to do her favorite activities. During an interview in RR #4's room on 9/10/13 at 7:20 PM, RR #4 confirmed that she smokes. RR #4 was asked if she receives assistance to go outside during smoking times. RR #4 stated, .They (staff) take me out to smoke, but you can only go at certain times. If you don't get up when it is time to go, you miss your time.
F 0151	**Honor all of the resident's rights as a resident of the nursing home, free of coercion and reprisal, and as a citizen or resident of the United States.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, review of the facility's smoking schedule, medical record review and interview, it was determined the facility failed to honor resident rights to smoke for 3 of 5 (Resident#158 and Random Residents (RR) 3 and 4) interviewable residents that smoke. The findings included: 1. Review of the facility's Smoking Policy documented, .Every resident who desires to smoke is permitted to do so if the center's interdisciplinary team has determined that the practice would be safe for the resident. 2. Review of the facility's SMOKING SCHEDULE DATED 7/25/13 documented, .9:00 A (AM), 10:30 A, 1:30 P (PM), 4:00 P, 7:00 P, 9:00 P. with the persons or department responsibility listed for each smoke time. 3. Medical record review for Resident #158 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the nurses CLINICAL HEALTH STATUS dated 9/6/13 documented Resident #158's short term and long term memory was marked as .OK (okay) .Additional notes. She was oriented to room and surroundings; instructed to call for assistance as needed. During an interview in Resident #158's room on 9/10/13 at 7:35 PM, Resident #158 confirmed that she does smoke but she is unable to walk and is dependent on staff to get her out of the bed. Resident #158 stated, .smoke time was 7 PM, I turned my light on for them to come to get me up so I could go smoke. I can't walk, I broke my hip. Resident #158 was asked how her light got turned off. Resident #158 stated, I cut my light on at 6:45 PM (for the 7:00 PM smoke time) and no one came. My light was turned off right before you came in. They finally came in here and got me off the bed into the wheelchair (wc) but I missed the smoke break. During an interview in the conference room on 9/10/13 at 3:00 PM, the Administrator confirmed that residents were allowed to smoke. The Administrator stated, It's their right. During an interview in the conference room on 9/10/13 at 4:30 PM, the Social Worker was asked who is responsible for coordinating the smoke breaks for the residents. The Social Worker stated, Smoke breaks are coordinated by the Director of Nursing and the Administrator. We know ahead of time who is in charge of taking the residents out to smoke. During an interview in the 600 hall on 9/11/13 at 8:05 AM, Certified Nursing Assistant (CNA) #1 was asked if Resident #158 could get up by herself. CNA #1 stated, No, she has to have help. She has a [MEDICAL CONDITION] During an interview in the east hall on 9/11/13 at 8:30 AM, CNA #2 was asked who is responsible for getting residents up so they can go out for smoke break. CNA #2 stated, It's ours, its the CNAs. 4. Medical record review for RR #3 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) Brief Interview for Mental Status (BIMS) dated 6/20/13 documented a score of 15 out of 15 indicating RR #3 is cognitively intact. Upon further review of the MDS, it was also documented that it is very important. for RR #3 to go outside to get fresh air when the weather is good. Review of the care plan dated 11/29/10 documented, .Smokes independently with supervision. Assist to and from Designated Smoking Area. During an interview in the 300 hall on 9/10/13 at 7:20 PM, RR #3 was asked if she receives help to get out of the bed when help is needed. RR #3 stated, .a couple of months ago went to bed before 9:00 (PM) smoke break and they wouldn't get me back up, so I just stay up in the wc from the time I get up until

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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 0151	(continued... from page 1) after smoke break. If I have to pee they come and change me. They have to use a standing lift to get me up. 5. Medical record review for RR #4 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the MDS Brief Interview for Mental Status dated 5/24/13 documented a score of 15 out of 15 indicating RR #4 is cognitively intact. Upon further review of the MDS, it was also documented that it is very important. for RR #4 to do her favorite activities. During an interview in RR #4's room on 9/10/13 at 7:20 PM, RR #4 confirmed that she smokes. RR #4 was asked if she receives assistance to go outside during smoking times. RR #4 stated, .They (staff) take me out to smoke, but you can only go at certain times. If you don't get up when it is time to go, you miss your time.
F 0157	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review and interview, it was determined the facility failed to notify the responsible party of a change in condition of 1 of 34 (Resident #111) sampled residents reviewed of the 34 residents included in the stage 2 review. The findings included: Review of the facility's Resident Rights: Maintaining Dignity and Respect in the Nursing Facility policy documented, .Inform each resident, family and their legal representative, if appropriate, of the resident's medical condition. Medical record review for Resident #111 documented an admitted d of 5/3/12 with [DIAGNOSES REDACTED]. Review of Resident #111's face sheet documented, .CONTACTS. (named nephew) Emergency Contact #1. Review of quarterly Minimum Data Sheet ((MDS) dated [DATE] documented Resident #111's cognitive status as severely impaired. During a family member telephone interview in the medical records office on 9/24/13 at 10:07 AM, the responsible party was asked if there been a change in Resident #111's condition within the past several months. The responsible party stated, Yes, .urinary tract infection, short of breath and blood in his stool and they did not call me. they did not notify me. I found out when I came to visit and his roommate told me. So I asked the nurse and she could not find anything about blood in his stool that's when she told me he had a urinary tract infection. During an interview at the west hall nurses' station on 9/26/13 at 8:50 AM, Nurse #4 was asked who do they (the staff) notify when there is a change in condition of the resident. Nurse #4 stated, We would notify the responsible party first. his brother is here everyday and we notify him of any changes. I worked that day. his brother was here when he went to the hospital and he was aware. We need to start notifying the responsible party on the chart.
F 0225	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, review of resident rights, review of a facility's investigation and interview, it was determined the facility failed to ensure a resident's allegation of abuse by facility staff was investigated for 1 of 5 (Resident #122) sampled residents reviewed for allegations of abuse during the complaint survey initiated on 9/10/13. The findings included: Review of the facility's Preventing Resident Abuse policy documented that allegations of abuse will be investigated by the facility's Administrator or the Director of Nursing (DON). Review of the facility's Resident Rights Under Federal Law documented, .The Resident has the right to be free from verbal, sexual, physical or mental abuse, corporal punishment and involuntary seclusion. Medical record review for Resident #122 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum (MDS) data set [DATE] documented the resident had a cognitive score of 13 out of a possible score of 15, indicating the resident was cognitively intact related to repetition, temporal orientation and recall. Review of the facility's investigation dated 7/26/13 documented, .When asked about incident (the facility's investigation of another resident's allegation of abuse, if a Named Certified Nursing Assistant (CNA #4) treated her roughly) resident (Resident #122) states (Named CNA #4) does not go to the extent that the other CNA's do and can be a little rough, does not explain what she is doing. Review of the facility's investigations of allegations of abuse documented no investigation into Resident #122's allegation of being treated roughly by CNA #4. During an interview in the conference room on 9/10/13 at 4:55 PM, the DON was asked if other residents had complained of the facility staff being rough with them during the facility's investigation of the reported allegation of abuse. The DON stated Resident #122 had stated the (Named CNA #4) is rough and slings her around and gets frustrated, and stated that CNA #4 stated, I don't have time for this. During an interview in the conference room on 9/10/13 at 7:50 PM, the Administrator was asked if during an investigation of allegations of abuse, when questioning other residents on the same hall, if a resident says the same CNA has been rough with me, should the allegation be investigated? The Administrator stated, Oh, I agree. Yes. The facility failed to investigate Resident #122's allegation of rough treatment by CNA #4.
F 0225	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, review of resident right's, review of the facility's investigation and interview, it was determined the facility failed to ensure a resident's allegation of staff abuse was investigated for 1 of 2 (Resident #122) residents of the 13 residents interviewed during the stage 1 review during annual survey. The facility failed to notify the family of a voiced allegation of abuse for 1 of 5 (Resident #2) sampled residents in the complaint survey. This finding was related to a substantiated allegation in a complaint investigation initiated on 9/10/13. The findings included: 1. Review of the facility's Preventing Resident Abuse policy documented that allegations of abuse will be investigated by the facility's Administrator or the Director of Nursing (DON). Review of the facility's Resident Rights Under Federal Law documented, .The Resident has the right to be free from verbal, sexual, physical or mental abuse, corporal punishment and involuntary seclusion. 2. Medical record review for Resident #122 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum (MDS) data set [DATE] documented the resident had a cognitive score of 13 out of a total possible score of 15, indicating the resident was cognitively intact related to repetition, temporal orientation and recall. Review of the facility's investigation dated 7/26/13 documented, .When asked about incident (during the facility's investigation of another resident's allegation of abuse, if a named Certified Nursing Assistant (CNA) treated her roughly) resident (#122) states (named CNA #4) does not go to the extent that the other CNA's do and can be a little rough, does not explain what she is doing. Review of the facility's investigations of allegations of abuse documented no investigation into Resident #122's allegation of being treated roughly by CNA #4. During an interview in the conference room on 9/10/13 at 4:55 PM, the Director of Nursing (DON) was asked if other residents had complained of the facility staff being rough with them during the facility's investigation of the reported allegation of abuse. The DON stated Resident #122 had (Named CNA #4) is rough and slings her around and gets frustrated. and stated that CNA #4 stated, I don't have time for this. During an interview in the conference room on 9/10/13 at 7:50 PM, the Administrator was asked if during an investigation of allegations of abuse, when questioning other residents on the same hall, if a resident says the same CNA (#4) has been rough with me, should the allegation be investigated? The Administrator stated, Oh, I agree. Yes. During an interview in Resident #122's room during the stage 1 resident interviews on 9/23/13 at 3:40 PM, Resident #122 was asked, .Has staff, a resident or anyone else here abused you - this includes verbal, physical or sexual abuse? Resident #122 stated, Yes, I told her she was rough. I mentioned it to a nurse. I don't know when. This resident interview resulted in the care area of abuse to be investigated during stage 2 of the annual survey. Review of the facility's documentation and interview related to Resident #122's allegation of abuse were initiated on 9/10/13 during an unannounced facility reported incident and complaint investigation. The facility failed to investigate Resident #122's stated concerns about the rough treatment by staff. 3. Medical record review for Resident #2 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of a quarterly Minimum Data Set ((MDS) dated [DATE] documented Resident #2's mental status as 11 out of 15 indicating Resident

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F 0225

(continued... from page 2)
#2 was moderately impaired. During a telephone interview on 9/10/13 at 2:00 PM, Resident #2's family member stated .they (the facility) did not notify us of the allegation of someone hitting (Named Resident #2) until she (Resident #2) told us on 5/25/13. During an interview in the conference room on 9/10/13 at 5:50 PM, the DON was asked what is the facility's policy related to notification of family on allegations of abuse. The DON stated, I'd have to read it, but I am sure it would say notify with any investigation. The DON was then asked if Resident #2's family was notified of Resident #2's allegation of abuse. The DON stated, We had a meeting with the family on 5/28/13. The DON was asked why didn't someone notify the family when the allegation was made. The DON stated, It didn't happen. The surveyor asked for clarification of what didn't happen. The DON stated, We did not notify the family when the allegation was made.

F 0226

Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on policy review, review of personnel files and interview, it was determined the facility failed to ensure pre-employment reference checks were conducted for 3 of 4 (Certified Nursing Assistants (CNA) #4, 8 and 9) staff members' personnel files reviewed. The facility failed to provide abuse prohibition training prior to the staff having direct contact with the residents living in the facility for 2 of 4 (CNAs #7 and 8) staff members' personnel files reviewed. The facility failed to notify the family of a voiced allegation of abuse by 1 of 5 (Resident #2) sampled residents. The findings included: 1. Review of the facility's Preventing Resident Abuse policy documented, .To prevent abuse, neglect, injuries of unknown sources and misappropriation of resident property, our company: Screens applicants by conducting reference checks with current and past employers. Teaches all associates and volunteers about what actions constitute abuse, their responsibilities to report alleged violations, how to deal with difficult situations and caregiver stress. 2. Review of personnel files revealed the facility failed to document that reference checks were conducted by the facility prior to hiring CNAs #4, 8 and 9. During an interview in the conference room on 9/11/13 at 12:40 PM, the Director of Nursing (DON) confirmed they were unable to provide documentation of reference checks for CNAs #4, 8 and 9 prior to their hire date. 3. Review of the personnel file revealed CNA #8 was hired 2/4/13 and did not have documented abuse prohibition training until 5/29/13. CNA #7 was hired 2/20/12 and did not have documented abuse prohibition training until 5/23/13. During an interview in the conference room on 9/11/13 at 12:40 PM, the DON was asked if CNA #7 had received abuse prohibition training during new employee orientation. The DON stated, No. During an interview in the business office on 9/26/13 at 10:15 AM, the Business Office Manager was asked for documentation of CNA #8's abuse prohibition training during new employee orientation. The Business Office Manager stated, I don't have it. Can't locate it. 4. During an interview in the conference room on 9/11/13 at 4:30 PM, the Administrator was asked, What kind of training is provided to staff about recognizing and reporting abuse? The Administrator stated, .trained upon hire. During an interview in the Minimum Data Set office on 9/26/13 at 8:15 AM, the Administrator was asked, What steps are taken to screen potential employees for a history of abuse? The Administrator stated, Abuse registry checked, background checks and reference checks before hire. 5. Medical record review for Resident #2 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of a quarterly Minimum Data Set ((MDS) dated [DATE] documented Resident #2's mental status as 11 out of 15 indicating Resident #2 was moderately impaired. During a telephone interview on 9/10/13 at 2:00 PM, Resident #2's family member stated .they (the facility) did not notify us of the allegation of someone hitting (Named Resident #2) until she (Resident #2) told us on 5/25/13. During an interview in the conference room on 9/10/13 at 5:50 PM, the DON was asked what is the facility's policy related to notification of family on allegations of abuse. The DON stated, I'd have to read it, but I am sure it would say notify with any investigation. The DON was then asked if Resident #2's family was notified of Resident #2's allegation of abuse. The DON stated, We had a meeting with the family on 5/28/13. The DON was asked why didn't someone notify the family when the allegation was made. The DON stated, It didn't happen. The surveyor asked for clarification of what didn't happen. The DON stated, We did not notify the family when the allegation was made.

F 0226

Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on policy review, review of personnel files and interview, it was determined the facility failed to ensure pre-employment reference checks were conducted for 3 of 4 (Certified Nursing Assistants (CNA) #4, 8 and 9) staff members' personnel files reviewed. The facility failed to provide abuse prohibition training prior to the staff having direct contact with the residents living in the facility for 2 of 4 (CNAs #7 and 8) staff members' personnel files reviewed. The facility failed to notify the family of a voiced allegation of abuse by 1 of 5 (Resident #2) sampled residents in the complaint investigation. The facility failed to ensure pre-employment reference checks were conducted for 1 of 11 (Nurse #9) staff members prior to hire. The findings included: 1. Review of the facility's Preventing Resident Abuse policy documented, .To prevent abuse, neglect, injuries of unknown sources and misappropriation of resident property, our company: Screens applicants by conducting reference checks with current and past employers. Review of Nurse #9's personnel file revealed no reference checks were conducted prior to hire of 3/20/13. During an interview in the business office on 9/24/13 at 4:00 PM, the Business Office Manager was asked to provide documentation of Nurse #9's reference checks prior to hire. The Business Office Manager stated, .Don't have a reference check. During an interview in the Minimum Data Set office on 9/26/13 at 8:15 AM, the Administrator was asked, What steps are taken to screen potential employees for a history of abuse? The Administrator stated, Abuse registry checked, background check, and reference checks before hire. 2. Review of the facility's Preventing Resident Abuse policy documented, .To prevent abuse, neglect, injuries of unknown sources and misappropriation of resident property, our company: Screens applicants by conducting reference checks with current and past employers. Teaches all associates and volunteers about what actions constitute abuse, their responsibilities to report alleged violations, how to deal with difficult situations and caregiver stress. 3. Review of personnel files revealed the facility failed to document that reference checks were conducted by the facility prior to hiring CNA #4, 8 and 9. During an interview in the conference room on 9/11/13 at 12:40 PM, the Director of Nursing (DON) confirmed they were unable to provide documentation of reference checks for CNA #4, 8 and 9 prior to their hire date. 4. Review of the personnel file revealed CNA #8 was hired 2/4/13 and did not have documented abuse prohibition training until 5/29/13. CNA #7 was hired 2/20/12 and did not have documented abuse prohibition training until 5/23/13. During an interview in the conference room on 9/11/13 at 12:40 PM, the DON was asked if CNA #7 had received abuse prohibition training during new employee orientation. The DON stated, No. During an interview in the business office on 9/26/13 at 10:15 AM, the Business Office Manager was asked for documentation of CNA #8's abuse prohibition training during new employee orientation. The Business Office Manager stated, I don't have it. Can't locate it. 5. During an interview in the conference room on 9/11/13 at 4:30 PM, the Administrator was asked, What kind of training is provided to staff about recognizing and reporting abuse? The Administrator stated, .trained upon hire. During an interview in the Minimum Data Set office on 9/26/13 at 8:15 AM, the Administrator was asked, What steps are taken to screen potential employees for a history of abuse? The Administrator stated, Abuse registry checked, background checks and reference checks before hire. 6. Medical record review for Resident #2 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of a quarterly Minimum Data Set ((MDS) dated
[DATE] documented Resident #2's mental status as 11 out of 15 indicating Resident #2 was moderately impaired. During a telephone interview on 9/10/13 at 2:00 PM, Resident #2's family member stated .they (the facility) did not notify us of the allegation of someone hitting (Named Resident #2) until she (Resident #2) told us on 5/25/13. During an interview in the conference room on 9/10/13 at 5:50 PM, the DON was asked what is the facility's policy related to notification of family on allegations of abuse. The DON stated, I'd have to read it, but I am sure it would say notify with any investigation. The DON was then asked if Resident #2's family was notified of Resident #2's allegation of abuse. The DON stated, We had a meeting with the family on 5/28/13. The DON was asked why didn't someone notify the family when the allegation was made. The DON stated, It didn't happen. The surveyor asked for clarification of what didn't happen. The DON stated, We did not notify the family when the allegation was made.

F 0279

Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured

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F 0279	(continued... from page 3) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined the facility failed to develop a plan of care with measurable goals and interventions to address the care and treatment of [REDACTED].#29, 31, 85 and 112) sampled residents included in the stage 2 review. The findings included: 1. Medical record review for Resident #29 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] and 7/18/1 documented the resident had impaired vision and did not have corrective lenses. During an interview in the Social Service's office on 9/25/13 at 4:45 PM, the MDS Nurse was asked if there was a care plan for Resident #29's impaired vision. The MDS Nurse looked through the care plan and stated, It's not there. The MDS Nurse was then asked if there should be a care plan for impaired vision. The MDS Nurse stated, Yes, there probably should be. The MDS Nurse was asked if Resident #29 had been seen by the optometrist. The MDS Nurse stated, I don't know, but will check with social worker and see. I will let you know. The MDS Nurse returned to the conference room on 9/25/13 at 4:55 PM. The MDS Nurse stated, No, hasn't been seen (Resident #29) but the social worker is going to take care of it. 2. Medical record review for Resident #31 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the care plan initiated 6/4/13 had no plan of care for dental problems. The MDS dated [DATE] documented Resident #31 had obvious broken natural teeth. Review of the care area assessment documented, .Teeth are in poor condition. During an interview in the Social Worker's office on 9/25/13 at 8:35 AM, the MDS Nurse was asked if dental triggered on the MDS and was there a care plan. The MDS Nurse stated, Yes, (triggered). I couldn't find one (care plan for dental). 3. Medical record review for Resident #85 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the MDS dated [DATE] documented Resident #85's vision was impaired. There was no care plan for vision. During an interview in the Social Worker's office on 9/25/13 at 5:25 PM, the MDS Nurse was asked if Resident #85 has a care plan for vision. The MDS Nurse stated, .not a vision care plan. The MDS Nurse was then asked if there should be a vision care plan. The MDS Nurse stated, Yeah, he (Resident #85) should. 4. Medical record review for Resident #112 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly MDS dated [DATE] documented Resident #112's vision is moderately impaired. There was no care plan for vision. During an interview in the Social Worker's office on 9/25/13 at 5:25 PM, the MDS nurse was asked if Resident #112 had a care plan for vision. The MDS Nurse stated, No, he doesn't. The MDS Nurse was then asked if Resident #112 should have a care plan for vision. The MDS Nurse stated, Yes, he should have a care plan for vision.
F 0282	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation and interview, it was determined the facility failed to follow care plan interventions related to falls, splinting devices and/or pressure ulcer relief for 3 of 27 (Residents #29, 112 and 157) sampled residents included in the stage 2 review. The findings included: 1. Medical record review for Resident #29 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) with an assessment reference date (ARD) of 4/19/13 did not document any falls since admission. Review of the care plan dated 5/16/13 and updated 8/19/13 documented, .Focus: At risk for falls related to: fell in past 30 days, History of falls. Interventions: Bed in low position. Body alarm when up in wheelchair and laying in bed. Observations in Resident #29's room on 9/24/13 at 7:28 AM, 9/25/13 at 7:27 AM and 9:20 AM, revealed Resident #29 lying in bed, with no bed alarm in place and the bed was not in a low position. During an interview at the east hall nurses' station on 9/26/13 at 8:20 AM, Nurse #8 confirmed Resident #29's bed was not in low position and there was no alarm in place. 2. Medical record review for Resident #112 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly MDS dated [DATE] documented Resident #112's functional range of motion was limited on one side. Review of the care plan dated 11/3/12 with revisions on 8/16/13 documented, .Monitor and report changes in ROM (range of motion) ability. Splint to r (right) hand and elbow. Patient to wear neuroflex restorative knee brace to right knee when up in chair. Observations in Resident #112's room on 9/23/13 at 12:30 PM and 5:15 PM, revealed Resident #112 sitting in a wheelchair (wc) with his right hand and arm contracted and pulled close to his chest, with no splint on. Observations in the west hall on 9/24/13 at 7:40 AM, Resident #112 was propelling himself down the hall in a wc. His right hand was contracted and his right arm was held close to his chest. There was no splint on his right hand, arm or knee. Observations in the dining room on 9/25/13 at 7:10 AM, revealed Resident #112 sitting in a wc eating breakfast with no splints on. Observations in Resident #112's room on 9/25/13 at 8:25 AM, revealed Resident #112 lying in bed on his right side, with no splints on. Observations in the west hall on 9/25/13 at 11:00 AM, revealed Resident #112 propelling himself in the hall with no splints on. Observations in Resident #112's room on 9/25/13 at 11:45 AM, revealed Resident #112 lying in bed on his left side, with no splints on. During an interview at the west hall nurses' station on 9/23/13 at 3:15 PM, Nurse #10 was asked if Resident #112 had a contracture. Nurse #10 stated, Yes, his right leg and arm. During an interview in the 300 west hall on 9/24/13 at 5:25 PM, Nurse #11 was asked if Resident #112 was wearing a splint. Nurse #11 stated, No. Nurse #11 was then asked if Resident #112 was wearing a leg brace. Nurse #11 stated, I think he just has that on (splint) when he is in bed. During an interview in the medical record office on 9/24/13 at 5:30 PM, Nurse #4 was asked when Resident #112 is supposed to wear his splints. Nurse #4 stated, He has that knee splint and he wears it at night for 8 hours. Nurse #4 was then asked about Resident #112's hand splint. Nurse #4 stated, He wears that at night too from 11-7. Well, I thought it was just an elbow splint the elbow splint was 8 hours too, he wears both at night. During an interview in Resident #112's room on 9/25/13 at 8:25 AM, Certified Nursing Assistant (CNA) #6 was asked if she applies any splints to Resident #112. CNA #6 stated, He is up when I come in the mornings, nights gets him up and bathed and dressed. He is supposed to wear them (splints) at night. During an interview in Resident #112's room on 9/25/13 at 3:50 PM, Licensed Physical Therapy Assistant (LPTA) #1 verified the knee brace should be on the resident when the resident is up in the wc with the foot rest elevated. During the interview this surveyor and the LPTA #1 noticed there were not any footrests on the wc. The facility did not follow the care plan interventions for the right hand and elbow splint or brace to right knee when up in chair. 3. Medical record review for Resident #157 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of a physician's orders [REDACTED]. During an interview at the east hall nurses' station on 9/25/13 at 4:50 PM, Nurse #3 was asked if a snack and redistribution cushion was sent to [MEDICAL TREATMENT] with the resident. Nurse #3 stated, We don't send a snack, her husband always has food for her and I don't know anything about sending a cushion with her. During an interview in the conference room on 9/25/13 at 5:20 PM, the Director of Nursing (DON) was asked if a cushion was being sent to [MEDICAL TREATMENT] with the resident. The DON stated, Didn't know it was on the care plan, but I will make sure the cushion is sent with her from now on.
F 0309	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review and interview, it was determined the facility failed to follow physician orders [REDACTED]. The findings included: Review of the facility's Blood Sugar Monitoring policy documented, .Check physician's orders [REDACTED]. Medical record review for Resident #26 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of a physician's orders [REDACTED]. accucheck q/month on 14th. Review of Resident #26's electronic Medication Administration Record [MEDICATION ADMINISTRATION RECORD DETAILS REDACTED]. The facility failed to follow physician orders [REDACTED]. During an interview in the conference room on 9/10/13 at 4:40 PM, the Director of Nursing (DON) confirmed there was an order for [REDACTED].
F 0313	**Make sure that residents receive proper treatment and assistive devices to maintain their vision and hearing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, it was determined the facility failed to ensure proper treatment and assistive devices were obtained to maintain visual ability for 1 of 3 (Resident #29) sampled residents with vision impairment of the 34 residents included in the stage 2 review. The findings included: Medical record review for Resident #29 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set ((MDS) dated [DATE] and 7/18/13 documented Resident #29 had impaired vision and did not have corrective lens. During an interview in the Social

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NAME OF PROVIDER OF SUPPLIER **GOLDEN LIVINGCENTER - SPRINGFIELD**		STREET ADDRESS, CITY, STATE, ZIP **104 WATSON ROAD** **SPRINGFIELD, TN 37172**	

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F 0313	(continued... from page 4) Worker's office on 9/25/13 at 4:45 PM, the MDS Nurse was asked if there was a care plan for Resident #29's impaired vision. The MDS Nurse looked through the care plan and stated, It's (the vision care plan) not there. The MDS Nurse was then asked if the resident had been seen by the optometrist. The MDS Nurse stated, I don't know but will check with the Social Worker and see. I will let you know. During an interview in the conference room on 9/25/13 at 4:55 PM, the MDS Nurse stated, No hasn't been seen (by optometrist), but the Social Worker is going to take care of it.
F 0314	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the National Pressure Ulcer Advisory Panel (NAUAP) Pressure Ulcer Prevention QUICK REFERENCE GUIDE, policy review, medical record review, observation and interview, it was determined the facility failed to ensure nurses weekly skin assessments were completed accurately to identify a pressure sore timely, obtain a physician's orders [REDACTED].#27, 7, 70 and 122) sampled residents with pressure sore included in the complaint and certification survey. The failure of the nurses to identify Resident #27's wound before it became unstageable and necrotic, resulted in actual harm. The failure to identify a pressure ulcer before it reached a stage 3, resulted in actual harm for Resident #7. A stage 3 pressure ulcer is full thickness skin loss involving damage or necrosis od subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue. The failure to put preventative measures in place on admission to prevent the development of a pressure ulcer for a resident who was identified as a high risk for pressure ulcers, resulted in actual harm when Resident #70 developed a pressure ulcer. The findings included: 1. Review of the NAUAP Pressure Ulcer Prevention QUICK REFERENCE GUIDE documented, .Ongoing assessment of the skin is necessary to detect early signs of pressure damage. Skin inspection should include assessment for localized heat, [MEDICAL CONDITION], or induration (hardness). Ask individuals to identify any areas of discomfort or pain that could be attributed to pressure damage. a number of studies have identified pain as a major factor for individuals with pressure ulcers. Accurate documentation is essential for monitoring the progress of the individual and to aiding communication between professionals. 2. Review of the facility's Clinical Guideline: Skin Integrity policy documented, .Purpose: To provide a systemic approach and monitoring process for skin. Objective: Decrease the prevalence and incidence of residents that develop pressure ulcers. Documentation of Weekly Skin Assessments. Licensed nurse will be responsible for performing this skin assessment. Pressure ulcer identified from admission skin assessment/weekly skin assessment. Notify physician and document notification. Print new treatment order and place on Treatment Administration Record (TAR). 3. Medical record review for Resident #27 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the annual Minimum Data Set ((MDS) dated [DATE] documented the resident was at risk for the development of pressure ulcers. Review of Resident #27's nurses' progress notes documented the following: a. 8/29/13 at 4:48 AM - Resident was found in the bathroom after a fall. The resident had a complaint of (c/o) .old pain to left hip. There was not a documented assessment of the hip. b. 8/29/13 at 3:30 PM - .Resident c/o left hip pain and stated she fell . Resident noted to have bruised area to left hip 3 cm (centimeters length) x (by) 3 cm (width). The X-ray was negative for a fracture. c. 8/30/13 at 11:30 AM - the resident was sent to the emergency room for evaluation related to an acute exacerbation of [MEDICAL CONDITION] and readmitted to the facility on [DATE] at 12:30 PM. The nurse's progress note upon readmission does not document the assessment of the left hip. d. 9/4/13 at 10:04 PM - .Resident in bed c/o pain in hip. There was not a documented assessment of the hip. e. 9/9/13 at 5:09 AM - .Resident continues to have pain to left hip and back. turned to right side to relieve pressure to the left hip, old bruise on that hip has enlarged since X-rays of hip and returning from hospital, applied padded drsg (dressing) for protection, and will notify wound nurse in am (morning) for further evaluation. Review of the WOUND EVALUATION FLOW SHEET dated 9/9/13, completed by Nurse #6, documented an unstageable, necrotic wound measuring 3 cm length by 3 cm width on the left hip. Santyl, a collagen specific enzyme that works to remove dead, necrotic tissue from a wound, was applied and the left hip wound was covered with a dressing. Review of the physician's orders [REDACTED]. Review of the nurses weekly skin assessment sheet dated 9/6/2013, 9/13/13 and 9/20/13 documented there were no skin concerns present on Resident #27's left hip. Observations in Resident #27's room on 9/24/13 at 9:30 AM, revealed Resident #27 had a circular black scabbed area on the left hip. Observations in Resident #27's room on 9/26/13 at 9:00 AM, revealed wound debridement, which was removal of the necrotic tissue from the left hip wound and dressing change by the Wound Specialist Nurse Practitioner and Nurse #6. The left hip wound measurements were 3 cm length x 3 cm width x 2 cm depth after partial debridement. The total depth of the left hip wound remained undeterminable. The wound bed still contained necrotic tissue. During an interview at the west hall nurses' station on 9/25/13 at 8:00 AM, Nurse #6 was asked when the treatments with Santyl had begun. Nurse #6 stated, I started the treatment on 9/9/13, when I was made aware. Yes, I started the treatment before I notified the Nurse Practitioner to get the order. it was a necrotic circular scabbed area on her left hip. During an interview on the 400 hall on 9/26/13 at 9:30 AM, the Wound Specialist Nurse Practitioner was asked if Resident #27 had a pressure wound. The Wound Specialist Nurse Practitioner stated, .This is definitely a pressure ulcer not a bruise. she will need more debridement and a possible wound vac (vacuum). The failure of the nurses to accurately complete weekly skin assessments of the left hip and failure to identify a wound before it became unstageable and necrotic, resulted in actual harm to Resident #27. 4. Medical record review for Resident #7 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the quarterly MDS dated [DATE] documented the resident was not at risk for pressure ulcers and there were no pressure ulcers present on the prior assessment. a. Review of the WOUND EVALUATION FLOW SHEET which was completed by the Treatment Nurse (TN), dated 5/28/13 documented, .R (right) heel. New wound found on heel. Partial necrosis. 10% (percent) Necrotic. L (length) 0.8 (centimeters (cm)) W (width) 1.8 centimeters. Stage II (2). This assessment of being a stage 2 is not accurate. The description of necrosis is actually a stage 3. During an interview at the east hall nurses' station on 9/24/3 at 9:50 AM, the TN was asked if Resident #7's necrotic right heel wound dated 5/28/13 had been staged correctly. The TN stated, .should have been staged a 3. Further review of the WOUND EVALUATION FLOW SHEET the TN documented on 7/1/13. (right heel had) Healed. Review of the nurses' weekly assessments dated 7/5/13, 7/12/13 and 7/19/13 documented treatment was being done to the right heel, yet the right heel had actually healed on 7/1/13. Review of the Wound Consult Note written by the Nurse Practitioner dated 8/21/13 documented the right heel has broken down again with the following description .Lateral right heel with evidence. Stage III pressure ulcer. Measures (L) 3 (cm) x (by) (W) 2 (cm) x (D) 0.1 cm, Large amt (amount) desiccated nonadherent, nonviable tissue with serosanguinous exudates and malodor after cleansing. This is the first time this new pressure ulcer was identified and a description documented. Review of the nurses' weekly assessments for the month of August 2013 had no documented skin concerns related to Resident #7's right heel, when Resident #7's right heel had broken down again on 8/21/13. b. Review of the WOUND EVALUATION FLOW SHEET dated 5/28/13 documented, Pressure Ulcer. L (left) heel. New wound on heel. Partial skin intact. The TN documented on this flow sheet of continued treatments through August 2013. Review of the nurses' weekly assessments for the month of August 2013 had no documented skin concerns related to Resident #7's left heel. The nurses' weekly assessments are inaccurate in that Resident #7 still has a left heel pressure ulcer with continued treatments. During an interview in the Assistant Director of Nursing's (ADON) office on 9/24/13 at 11:00 AM, the ADON was asked if the nurses were accurately documenting the condition of Resident #7's skin on the weekly assessments sheets. The ADON stated, .The nurses are suppose to go in and look at the resident from head to toe weekly. They should be more accurate. During an interview in the MDS office on 9/26/13 at 9:30 AM, the Director of Nursing (DON) was asked if the nurses were accurately completing the weekly skin assessments sheets. The DON stated, .We have identified problems with the skin assessments. nurses were doing inaccurate assessments. Review of the care plan dated 5/31/13 documented, .Right and left Prevolon boots at all times. Review of a physician's orders [REDACTED]. Observations in Resident #7's room on 9/10/13 at 4:20 PM and at 7:00 PM, revealed Resident #7 lying in bed with a functioning air mattress. Resident #7 was not observed to have Prevolon boots on nor were the resident's heels floated. Observations in Resident #7's room on 9/11/13 at 10:00 AM, revealed Resident #7's right heel wound was closed and the left heel wound treatment was provided as ordered. The Prevolon boots were not put on and the resident's heels were not floated following the treatment. Observations in Resident #7's room on 9/24/13 at 4:10 PM, revealed Resident #7 did not have Prevolon boots on nor were the heels floated. Observations at the west hall nurses' station on 9/24/13 at 5:15 PM, revealed Resident #7 sitting up in a Broda chair without the Prevolon boots on. Observations in Resident #7's room on 9/25/13 at 9:20 AM, revealed Resident #7 up in a Broda chair without the Prevolon boots on. Observations in Resident #7's room on 9/25/13 at 11:00 AM, revealed Resident #7 lying in the bed without the Prevolon boots

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F 0314	(continued... from page 5) on nor were the heels floated. Observations in the west hall day room on on 9/25/13 at 11:20 AM, revealed Resident #7 did not have the Prevolon boots on. During an interview in Resident #7's room on 9/24/13 at 4:10 PM, certified nursing assistant (CNA) #3 was asked what measures were taken toward prevention and/or avoid deterioration of the resident's pressure wounds. CNA #3 stated, .Repositioning, pillows between legs. under her feet and legs. CNA #3 was then asked if Resident #7 was to wear Prevolon boots. CNA #3 stated, .If she is up, we put them on everyday. During an interview in the MDS office on 9/26/13 at 9:30 AM, the Director of Nursing (DON) was asked about Resident #7's care plan interventions and physician orders [REDACTED]. The failure of the nurses to accurately complete weekly skin assessments and failure to identify a pressure ulcer before it became a stage 3, resulted in actual harm to Resident #7. 5. Medical record review for Resident #70 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the braden scale for predicting pressure sore risk dated 2/26/13 documented the resident was at high risk for developing pressure ulcers. There was no initial admission care plan intervention to prevent pressure ulcer development for Resident #9 who was identified as a high risk for pressure ulcers. Review of Resident #70's progress notes documented: a. 3/8/13 - .Change of Condition. called to room by technician, blister observed to left heel. b. 3/12/13 - .New fluid filled blister noted to right heel. Right and left Prevolon boots placed on resident. c. 5/8/13 - .Change of Condition. Doppler result reveal [MEDICAL CONDITIONS] bilat (bilateral) legs. mild to moderate [MEDICAL CONDITION] d. 6/20/13 - .Treatment con't (continue) to bilateral heels. Received treatment at wound clinic with debridement noted. e. 7/28/13 - .Resident ABT (antibiotic) /rt (right) heel wound, wound vac (vacuum) secure. f. 7/30/13 - .isolation [MEDICAL CONDITIONS] of wound. g. 8/7/13 - .ABT [MEDICAL CONDITION] in foot wounds. wound vac to left foot for suction. h. 8/14/13 - .Wound Consult Note: Pt (patient) referred with bilateral heel ulcers. Impression-right heel and left heel Stage IV pressure ulcers with [MEDICAL CONDITION] positive wound tissue cultures. The original care plan was dated 3/14/13 and documented, .Altered skin integrity. Heels at risk. Prevolon boots. The left heel ulcer developed 3/8/13 and the right heel ulcer developed 3/11/13. Review of the care plan dated 8/1/13 documented, .Float heels. Heel boots. Review of a physician's orders [REDACTED]. Review of the nurse weekly skin assessments dated 5/6/13 had no documented skin concerns related to Resident #70's left and right heels. Observations in Resident #70's room on 9/23/13 at 3:05 PM, revealed the left heel wound with no open areas. The right heel wound had a black scabbed area and measured length (L) 1 cm by (x) width (W) 0.4 cm. Wound care was provided as ordered. Resident's heels were resting on the mattress following wound treatment without Prevolon boots on and at 4:50 PM the resident's bilateral extremities were elevated on a pillow with her heels resting on the pillow without Prevolon boots on. During an interview in the MDS office on 9/25/13 at 4:00 PM, Nurse #1 was asked if there was anything in place to try to prevent Resident #70's wounds from developing on 3/8/13 and 3/11/13. Nurse #1 stated, .something would be expected to have been put into place upon admission since the resident had a high risk braden score. In reference to the care plan interventions dated 3/14/13, Nurse #1 stated, .That should have been in place from the get go. Nurse #1 was asked if the nurses were completing the weekly skin assessments sheets accurately. Nurse #1 stated, .Nurses may just get into the habit of just going down the wound evaluation list making check marks. The failure to put preventative measures in place on admission to prevent the development of a pressure ulcer for a resident who was identified as a high risk for pressure ulcers, resulted in actual harm when Resident #70 developed a pressure ulcer. 6. Medical record review for Resident #122 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the admission MDS dated [DATE] documented the resident had an unhealed stage 4 pressure ulcer present at the time of admission to the facility. Review of the nurses weekly skin assessment sheet for February 2013 documented on 2/4/13 the resident's skin on the coccyx was intact. Observations in Resident #122's room on 9/25/13 at 1:20 PM, revealed the coccyx pressure ulcer is a stage 3 - 2 x 1 x 1.2 cm. A stage 3 pressure ulcer is full thickness skin loss involving damage or necrosis od subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue. During an interview in Resident #122's room on 9/25/13 at 1:20 PM, Nurse #6 confirmed the wound on Resident #122's coccyx had required ongoing treatment since the resident's admission to the facility on [DATE]. During an interview in the MDS office on 9/26/13 at 9:15 AM, the Director of Nursing (DON) was asked if the nurse's documentation of intact skin on Resident #122's coccyx dated 2/4/13 was correct. The DON stated, No.
F 0318	**Make sure that residents with reduced range of motion get propertreatment and services to increase range of motion.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation and interview, it was determined the facility failed to ensure treatment and services were provided to prevent further decline in range of motion for 1 of 3 (Resident #112) sampled residents reviewed with contractures included in the stage 2 review. The findings included: Medical record review for Resident #112 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of a hospital History and Physical dated 9/30/12 documented .patient's past history includes [MEDICAL CONDITION] in February 2012. He was left with a contracture right [MEDICAL CONDITION] and was unable to ambulate following [MEDICAL CONDITION]. Review of the quarterly Minimum Data Set ((MDS) dated [DATE] documented Resident #112's functional range of motion was limited on one side. Review of a physician's orders [REDACTED]. (patient) to have R (right) resting hand splint and elbow splint. patient to wear neuroflex restorative knee brace to right knee when up in chair. Review of the care plan dated 11/3/12 with revisions on 8/16/13 documented, .Monitor and report changes in ROM (range of motion) ability. Splint to r (right) hand and elbow. Patient to wear neuroflex restorative knee brace to right knee when up in chair. Observations in Resident #112's room on 9/23/13 at 12:30 PM and 5:15 PM, revealed Resident #112 sitting in a wheelchair (wc) with his right hand and arm contracted and pulled close to his chest, with no splint on. Observations in Resident #112's room on 9/23/13 at 2:45 PM, revealed Resident #112 in bed with no splint on. Observations in the west hall on 9/24/13 at 7:40 AM, Resident #112 was propelling himself down the hall in a wc. His right hand was contracted and his right arm was held close to his chest. There was no splint on his right hand, arm or knee. Observations in the dining room on 9/25/13 at 7:10 AM, revealed Resident #112 sitting in a wc eating breakfast with no splints on. Observations in Resident #112's room on 9/25/13 at 8:25 AM, revealed Resident #112 lying in bed on his right side, with no splints on. Observations in the west hall on 9/25/13 at 11:00 AM, revealed Resident #112 propelling himself in the hall with no splints on. Observations in Resident #112's room on 9/25/13 at 11:45 AM, revealed Resident #112 lying in bed on his left side, with no splints on. During an interview at the west hall nurses' station on 9/23/13 at 3:15 PM, Nurse #10 was asked if Resident #112 had a contracture. Nurse #10 stated, Yes, his right leg and arm. During an interview in the 300 west hall on 9/24/13 at 5:25 PM, Nurse #11 was asked if Resident #112 was wearing a splint. Nurse #11 stated, No. Nurse #11 was then asked if Resident #112 was wearing a leg brace. Nurse #11 stated, I think he just has that on (splint) when he is in bed. During an interview in the medical record office on 9/24/13 at 5:30 PM, Nurse #4 was asked when Resident #112 is supposed to wear his splints. Nurse #4 stated, He has that knee splint and he wears it at night for 8 hours. Nurse #4 was then asked about Resident #112's hand splint. Nurse #4 stated, He wears that at night too from 11-7. Well, I thought it was just an elbow splint the elbow splint was 8 hours too, he wears both at night. During an interview in Resident #112's room on 9/25/13 at 8:25 AM, Certified Nursing Assistant (CNA) #6 was asked if she applies any splints to Resident #112. CNA #6 stated, He is up when I come in the mornings. Nights gets him up and bathed and dressed. He is supposed to wear them (splints) at night. During an interview in Resident #112's room on 9/25/13 at 3:50 PM, Licensed Physical Therapy Assistant (LPTA) #1 verified the knee brace should be on the resident when the resident is up in the wc with the foot rest elevated. During the interview this surveyor and the LPTA #1 noticed there were not any footrests on the wc. During an interview in the conference room on 9/25/13 at 4:00 PM, the Director of Nursing (DON) was asked what her expectations were when there is a signed physician's orders [REDACTED]. The resident was not observed wearing the neuroflex splint as ordered by the physician when up in chair. The facility did not follow the physician's orders [REDACTED].
F 0323	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation and interview, it was determined the facility failed to ensure fall interventions were in place for 1 of 3 (Resident #29) sampled residents with falls of the 34 residents included in the stage 2 review. The findings included: Medical record review for Resident #29 documented an admission date of [DATE] with

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LIVINGCENTER - SPRINGFIELD	**104 WATSON ROAD** **SPRINGFIELD, TN 37172**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0323

(continued... from page 6)
[DIAGNOSES REDACTED]. Review of the fall risk assessment dated [DATE] documented a score of 17-with a score greater than 10
deems resident is at risk for falls. Review of the Minimum (MDS) data set [DATE] documented 2 or more falls since last assessment and a cognitive score of 2 indicating Resident #29 was severely impaired in decision-making skills. The care plan initiated on 5/16/13 with new interventions documented the following falls with interventions: 5/15/13 bed in low position, 5/26/13 gait belt with transfers, 7/15/13 encourage resident to be up for meals and 8/10/13 body alarm. Observations in Resident #29's room on 9/24/13 at 7:28 AM, 9/25/13 at 7:27 AM and 9:20 AM, revealed Resident #29 lying in bed, with no bed alarm in place and the bed was not in a low position. During an interview at the east hall nurses station on 9/23/13 at 12:14 PM, Nurse #3 was asked if Resident #29 had a fall within the last 30 days. Nurse #3 stated, Yes, 9/22/13 no injuries. During an interview at the east hall nurses' station on 9/26/13 at 8:20 AM, Nurse #8 confirmed Resident #29's bed was not in low position and there was no alarm in place. The facility did not follow interventions for falls related to body alarm and bed in low position.

F 0325

Make sure that each resident gets a nutritional and well balanced diet, unless it is not possible to do so.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on review of meal tray cards, medical record review, observation and interview, it was determined the facility failed to follow physician's orders for therapeutic foods necessary to maintain the nutritional status of 1 of 3 (Resident #112) sampled residents of the 34 residents included in the stage 2 review. The findings included: Medical record review for Resident #112 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the care plan dated 1/22/13 documented, .Predicted Suboptimal Nutrient Intake R/T (related to) poor intake. Diet as ordered. Review of a physician's order dated 8/20/13 documented, .Diets. Regular. Mechanical Soft. Fortified foods with all meals. scoop plate with meals. Review of a physician's order dated 9/16/13 documented, .DIETS. Mechanical Soft Special Instructions: Fortified foods with all meals. Review of a nutrition assessment dated [DATE] documented, .Regular Mech (mechanical) Soft Diet with fortified food. Review of Resident #112's tray cards for breakfast, noon and evening meals documented, .FORTIFIED FOODS. Observations in the dining room on 9/24/13 at 5:15 PM, revealed Resident #112 eating, with 1/2 of his meal eaten. Resident #112's tray consisted of ham and beans, greens and a cornbread muffin. During an interview in the dining room on 9/24/13 at 5:15 PM, the Certified Dietary Manager (CDM) was asked what was served tonight for fortified foods. The CDM stated, Creamed potatoes and vegetable soup. The CDM was then asked what Resident #112 had on his tray that was fortified. The CDM stated, .he is not fortified. The CDM began looking at the diet slip and again stated, He is not fortified. Oh, yes he is. The CDM then brought the resident creamed potatoes. During an interview in the dining room on 9/25/13 at 8:05 AM, the Registered Dietician (RD) was asked what is being done for Resident #112's nutritional status. The RD stated, He gets fortified foods mashed potatoes, soups and fortified oats for breakfast. The resident did not receive fortified foods with his evening meal on 9/24/13, until the surveyor asked what the fortified foods were for the evening meal.

F 0364

Prepare food that is nutritional, appetizing, tasty, attractive, well-cooked, and at the right temperature.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on review of tray line temperatures, review of a test tray, medical record review, observation and interview, it was determined the facility failed to serve food that was palatable for 3 of 13 (Residents #81, 90 and 122) sampled residents of the 13 residents interviewed during the stage 1 review. The findings included: 1. Medical record review for Resident #81 documented an admission date of [DATE]. Review of the Minimum Data Set ((MDS) dated [DATE] documented a cognitive status score of 15 out of 15 indicating the resident was cognitively intact. During an interview in Resident #81's room 9/23/13 at 2:38 PM, Resident #81 was asked if the food tastes good and looks appetizing. Resident #81 stated, No, not seasoned and things I don't like. Resident #81 was asked if the food was served at the proper temperature. Resident #81 stated, No, cold, my children bring me food at night. 2. Medical record review for Resident #90 documented an admission date of [DATE]. Review of the MDS dated of 8/13/13 documented a cognitive status score of 15 out of 15 indicating the resident was cognitively intact. During an interview in Resident #90's room on 9/23/13 at 3:22 PM, Resident #90 was asked if the food tastes good and looks appetizing. Resident #90 stated, No, not to me. 3. Medical record review for Resident #122 documented an admission date of [DATE]. Review of the MDS dated [DATE] documented a cognitive status score of 13 out of 15 indicating the resident was cognitively intact. During an interview in Resident #122's room on 9/23/13 at 3:48 PM, Resident #122 was asked if the food was served at the proper temperature. Resident #122 stated, It is cold quiet often. 4. Observations in the dietary department on 9/25/13 at 11:30 AM, revealed tray line temperatures as follows: mashed sweet potatoes 158 degrees, pureed squash 140 degrees, fried squash 160 degrees and pork loin 160 degrees. Observations of the temperature and palatability test tray after the last resident tray was served on 9/25/13 at 12:45 PM, revealed the following temperatures: pork loin 80 degrees and dry, sweet potatoes 100 degrees and palatable, squash 110 degrees and palatable. The temperature of the pork loin dropped 80 degrees. During an interview on the east hall on 9/25/13 at 12:45 PM, the Dietary Manager stated, It (pork loin) tastes dry.

F 0371

Store, cook, and serve food in a safe and clean way

Based on policy review, observation and interview, it was determined the facility failed to ensure foods were prepared under sanitary conditions as evidenced by hair nets not covering the hair while food was being prepared, improper thawing of meat and dirty dishes kept where thawed fruits and vegetables were washed on 3 of 4 (9/23/13, 9/25/13 and 9/26/13) days of observations in the kitchen. The findings included: 1. Review of the facility's Dining Services Employee Hair Guidelines documented, .Two hairnets or bouffant caps may be worn to cover hair completely. Observations during tour in the kitchen on 9/23/13 at 10:43 AM, revealed the cook's hair was uncovered approximately an inch around her hairline. 2. Observations in the kitchen on 9/25/13 at 9:24 AM, revealed dirty utensils such as a pot, containers, a pitcher and scoops in the vegetable sink. 3. Observation in the kitchen on 9/26/13 at 1:40 PM, revealed a tea container, a lid and plastic container in the right side of the 2 compartment sink and raw fish fillets in a rectangular pan sitting in standing water in the left side of the 2 compartment sink. There was no running water over the thawing fish. During an interview in the kitchen on 9/26/13 at 1:50 PM, the Certified Dietary Manager (CDM) was asked when the 2 compartment sink was sanitized and if there was a schedule. The CDM stated, .would be sanitized before each use. no don't have a schedule. The CDM then confirmed the thawing meat should be under running water.

F 0412

Provide or obtain dental services for each resident.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on medical record review, observation and interview, it was determined the facility failed to provide care and services related to the resident's dental /oral health in accordance with the assessment for 1 of 3 (Resident #31) sampled residents with dental needs of the 34 residents included in the stage 2 review. The findings included: Medical record review for Resident #31 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set
((MDS) dated [DATE] documented, Resident #31 had obvious likely cavities or broken natural teeth. Review of the care area assessment dated [DATE] documented Resident #31 had broken teeth and the teeth were in poor condition. Observations in Resident #31's room on 9/23/13 at 2:21 PM, revealed Resident #31 had a missing tooth in the front and in the back. Observations in Resident #31's room on 9/25/13 at 10:25 AM, revealed Resident #31 had missing and broken teeth. During an interview in Resident #31's room on 9/23/13 at 2:18 PM, Resident #31 was asked if you have tooth problems, gum problems, mouth sores or denture problems. Resident #31 stated, Yes, broken teeth.

F 0431

Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.

Based on policy review, observation and interview, it was determined the facility failed to ensure medications were stored safe and secured in 1 of 6 (600 hall medication cart) medication storage areas. The findings included: Review of the

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F 0431	(continued... from page 7) facility's medication administration policy documented, .Cart may remain unlocked only when in direct line of sight and control by the nurse. who is administering medications. Observations on the 600 hall on 9/24/13 at 5:15 PM, revealed the 600 hall medication cart was unlocked, unattended and out of the nurse's view. During an interview on the 600 hall on 9/24/13 at 5:20 PM, Nurse #3 was asked if she knew her cart was unlocked. Nurse #3 stated, Yes ma'am. When I came out of the room I told Mr. (named a resident). Oh, my God, I left my cart unlocked that's a mortal sin.
F 0441	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure proper infection control practices were followed to prevent the potential spread of infection when 1 of 1 (Nurse #6) nurse failed to change gloves, perform hand hygiene at the appropriate time and turned the faucet off with bare hands during 2 of 3 dressing changes; 1 of 1 (Nurse #1) nurse failed to clean the accucheck machine with a bleach wipe and 1 of 8 (Nurse #2) nurses observed administering medications touched medications with her bare hands. The facility failed to ensure 4 of 9 staff members (Certified Nursing Assistants (CNA) #6, CNA #5, Activity Director and Treatment Nurse) followed infection control practices to prevent the potential spread of infection initiated during the complaint survey of 9/10/13 and completed with the certification survey of 9/2613. The findings included: 1. Review of the facility's Clean Dressing Change Audit policy documented, .Cleanse wound with prescribed solution, working from inside out. Wash hands and put on clean pair of gloves. Apply prescribed dressing and secure per order. Review of the facility's Handwashing/Hand Hygiene policy documented, Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions. Before and after entering isolation precaution settings. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel. 2. Medical record review for Resident #136 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the microbiology report dated 8/19/13 documented, .8/19/13 . MRSA. Observations during a dressing change in Resident #136's room on 9/25/13 at 4:20 PM, Nurse #6 washed her hands, applied gloves, wet a 4 by (x) 4 in a container of normal saline and cleaned the wound on the right outer ankle. Without changing her gloves and washing her hands, Nurse #6 moistened a 4x4 in the same container of normal saline, folded it in quarters, and applied the moist dressing to the wound. Nurse #6 removed her gloves and washed her hands, applied gloves, wet two more 4x4's in the same normal saline she had wet the previous 4x4's in with her contaminated glove from the previous wound cleansing, and cleaned the 2nd wound on the metatarsal head of the right foot. Nurse #6 then folded the second moistened 4x4 she had wet in the contaminated normal saline and applied it to the wound as a moist dressing. During an interview on the west hall on 9/26/13 at 12:37 PM, Nurse #6 was asked if she knew what she had done during the dressing change. Nurse #6 stated, .When I cleaned the wound, I should have thrown the 4x4 away and washed my hands before dressing the wound. During an interview in the Administrator's office on 9/25/13 at 6:25 PM, the Director of Nursing (DON) was informed of the above observations and was asked what she would have expected the nurse to do. The DON stated, .I think it was, okay but I would have to check our policy. but when she removed the old dressing, I think the wound would have been clean. 3. Medical record review for Resident #122 documented an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the Wound Consult note dated 9/25/13 documented, .Right medial ankle with ruptured hemorrhagic blister. Right heel with discoloration, district margin, small 1.5 cm (centimeter) hemorrhagic area. Cover with [MEDICATION NAME] and non-adherent dsg (dressing). Observations during a dressing change in Resident #122's room on 9/25/13 at 1:20 PM, Nurse #6 gathered the needed supplies, set the supplies out at the resident's bedside on a barrier on the over-bed table, washed hands with soap and water and turned the faucet off with her bare hands. Nurse #6 dried her hands, applied gloves, removed the old dressing, removed her gloves, washed hands with soap and water and turned the faucet off with her bare hands. Nurse #6 dried her hands, applied gloves, applied medication and a dressing to the wound, removed her gloves, washed hands with soap and water, turned the faucet water off with bare hands and her dried hands. During an interview in the Minimum Data Set (MDS) office office on 9/26/13 at 12:50 PM, Nurse #6 was asked, What is the correct procedure for hand-washing? Nurse #6 stated, Get soap and water after turning on the faucet. Lather for 15 seconds. Take a paper towel and turn off the faucet. 4. Review of the facility's BLOOD GLUCOSE MONITOR DECONTAMINATION policy documented, .PURPOSE: To implement a safe and effective process for decontaminating blood glucose monitors. A wipe that is EPA (Environmental Protection Agency) registered as tuberculocidal; effective against HIV (Human Immunodeficiency Virus), HBV (Hepatitis B Virus), and a broad spectrum of bacteria will be utilized to clean the monitor. POLICY: The blood glucose monitor will be cleaned and disinfected with wipes following use on each resident when monitors are shared by multiple residents. Observations on the 500 hall on 9/24/13 at 4:37 PM, Nurse #1 performed an accucheck on Resident #107. Nurse #1 cleaned the glucometer with an alcohol prep. During an interview on the 600 hall on 9/25/13 at 3:20 PM, Nurse #1 was asked about cleaning of the glucometer. Nurse #1 stated, I cleaned it with alcohol, but I should have used a bleach wipe. During an interview in the conference room on 9/25/13 at 5:20 PM, the Director of Nursing (DON) was asked how glucometers were to be cleaned. The DON stated, They are to be cleaned with wipes that have bleach and not alcohol. 5. Review of the facility's Medication Administration-Orals policy documented, .Avoid touching any of the medication with fingers. Observations on the 500 hall on 9/25/13 at 8:48 AM, Nurse #2 prepared to administer medications to Resident #48. Nurse #2 pulled the bottle of medication from the cart drawer, poured the tablet into her bare hand and then broke the tablet in half with her bare hand. During an interview in the conference room on 9/25/13 at 5:25 PM, the DON was asked if it was acceptable for nurses to handle pills with their bare hands. The DON stated, No, that's not acceptable. If (pill) taken from a bottle, should pour pill into top of bottle and then pour into the med (medication) cup. 6. Observations on the 400 hall on 9/10/13 at 4:30 PM, CNA #6 donned a mask and gloves, entered a resident's room posted with isolation precautions, picked up the resident's plastic drinking cup, removed her mask and gloves, carried the cup to the nurses' station area, filled the cup with ice from the community ice chest, returned to the resident's room, gave the resident the cup, exited the room and used hand sanitizer to clean her hands. During an interview at the west hall nurses station, Nurse #2 was asked if it is okay to take drinking cups out of an isolation room, fill them at the ice chest and take the back into the isolation room. Nurse #2 stated, No. Nurse #2 was then asked what precautions should be taken when entering a respiratory isolation room. Nurse #2 stated, Mask, gloves and an isolation gown if needed for direct contact care. 7. Observations on the 700 hall on 9/23/13 at 11:55 AM, CNA #5 donned an isolation gown and gloves, entered a resident's room posted with isolation precautions, set up the meal tray, removed gloves and gown, exited room and cleaned hands with hand sanitizer. 8. Observations on the 700 hall on 9/23/13 at 12:50 PM, the Activity Director entered a resident's room posted with isolation precautions, spoke to the resident, exited the room and did not clean her hands with sanitizer or soap and water. 9. Observations during wound care in Resident #9's room on 9/23/12 at 3:05 PM, the Treatment Nurse (TN) gathered the necessary supplies for the dressing change, entered the residents room, set up the supplies at the resident's bedside, washed her hands, turned the water off with wet bare hands, dried her hands, donned gloves, used the hand held device to raise the bed, removed the resident's covers, removed the old dressing, measured the right heel wound, removed her gloves, washed her hands, turned the faucet off with wet bare hands, then dried her hands. The TN donned gloves, performed the treatment as ordered, removed her gloves, washed her hands, turned the water off with wet bare hands, then dried her hands. The TN donned gloves, removed the old dressing from the left foot, removed her gloves, washed her hands, turned the water off with wet bare hands, then dried her hands, applied gloves, performed the wound treatment as ordered, removed her gloves, washed her hands, turned the water off with wet bare hands, then dried her hands. During an interview in the Minimum Data Set office on 9/26/13 at 12:50 PM, the TN was asked, What is the correct procedure for hand-washing? The TN stated, Get soap and water after turning on the faucet. Lather for 15 seconds. Take a paper towel and turn off the faucet.