STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445148	A. BUILDING _____ B. WING _____	08/13/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DONELSON PLACE CARE & REHABILITATION CENTER	2733 MCCAMPBELL AVENUE NASHVILLE, TN 37214

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 0279 **Level of harm** - Actual harm **Residents Affected** - Few	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview the facility failed to develop a comprehensive care plan to address repositioning needs for one resident (#4) of six residents reviewed. The facility's failure to develop a comprehensive care plan for repositioning resulted in harm to resident #4. The findings included: Resident #4 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the Quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident was severely cognitively impaired, and required the assist of two or more people for bed mobility .A. bed mobility-how resident moves to and from lying position, turns side to side, and positions body while in bed. Medical record review of the resident's Care Plan revealed no care plan was developed to address the resident's positioning needs. Review of facility investigation dated March 25, 2014, revealed, .CNA (Certified Nurse Assistant) stated that when turning the resident to provide care, a popping sound was heard. Observing a 'knot' on the resident's leg CNA immediately notified nurse. Medical record review of hospital History and Physical dated March 26, 2014, revealed, .patient .presents to the emergency room from (resident's) place of residence.where (the resident) was being rolled over in bed by (resident's) caretakers and a notable anatomical deformity was noted.noted a left comminuted (a fracture in which the bone has broken into several pieces) femur fracture. Review of facility policy, revised April 2013, Repositioning, revealed, .Repositioning the resident in bed.1. Check the care plan, assignment sheet or the communication system to determine resident's specific positioning needs including special equipment, resident level of participation and the number of staff required to complete the procedure.9. Use two people and a draw sheet to avoid shearing while turning. Interview with CNA #1 on August 13, 2014, at 12:50 p.m., by phone, revealed the CNA was providing personal care to resident #4 on March 25, 2014, in the resident's room. Continued interview with CNA #1 revealed the CNA .went in to change (resident).laying on back, changed (resident) turned pad and rolled toward window, laid (resident) back down and ready to turn toward door and heard 'pop'.didn't know anything was wrong until turned (resident) back on (resident's) back and saw abnormality. Further interview with CNA #1 confirmed the CNA had repositioned the resident alone, .there was nobody with me. Continued interview with the CNA revealed, .(resident) was able to assist some., and CNA #1 confirmed the CNA had .turned the resident all the time. without help from another CNA. Further interview confirmed the CNA would .just go ahead and do it.had to have two people to get (resident) out of bed but (resident) was an easy turn. Continued interview revealed the CNA was aware of how much assistance a resident required .it would be on (resident's) chart or we know if resident makes a motion that resident can assist and will use one person. Interview with the Director of Nursing (DON) on August 13, 2014, at 1:15 p.m., in the Training Room, confirmed the facility failed to develop a comprehensive care plan to address the positioning needs of the resident. This failure resulted in harm to resident #4. C/O #
F 0323 **Level of harm** - Actual harm **Residents Affected** - Few	**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, review of a facility investigation, review of facility policy, and interview, the facility failed to provide assistance with repositioning to prevent injury for one resident (#4) of six residents reviewed. The facility's failure to provide assistance of two staff with repositioning resulted in harm to resident #4. The findings included: Resident #4 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Medical record review of the Quarterly Minimum Data Set (MDS) dated [DATE], revealed the resident was severely cognitively impaired, and required the assist of two or more people for bed mobility .A. bed mobility-how resident moves to and from lying position, turns side to side, and positions body while in bed. Medical record review of the resident's Care Plan revealed no care plan was developed to address the resident's positioning needs. Review of facility investigation dated March 25, 2014, revealed, .CNA (Certified Nurse Assistant) stated that when turning the resident to provide care, a popping sound was heard. Observing a 'knot' on the resident's leg CNA immediately notified nurse. Medical record review of hospital History and Physical dated March 26, 2014, revealed, .patient .presents to the emergency room from (resident's) place of residence.where (the resident) was being rolled over in bed by (resident's) caretakers and a notable anatomical deformity was noted.noted a left comminuted (a fracture in which the bone has broken into several pieces) femur fracture. Review of facility policy, revised April 2013, Repositioning, revealed, .Repositioning the resident in bed.1. Check the care plan, assignment sheet or the communication system to determine resident's specific positioning needs including special equipment, resident level of participation and the number of staff required to complete the procedure.9. Use two people and a draw sheet to avoid shearing while turning. Interview with CNA #3 on August 12, 2014, at 4:10 p.m., in the 100 Long Hallway, revealed the CNA's understanding of the amount of assistance a resident required with repositioning was if the resident was not independent .then have to get another CNA . Continued interview confirmed CNA's and nurses also communicated the amount of assistance each resident required during their shift change report. Continued interview confirmed, .also have care plans on inside closet door . which the CNA would utilize to determine the amount of assistance a resident required. Interview with LPN #4 on August 12, 2014, at 4:20 p.m., at the A Wing Nurse Station, revealed the nurse's and CNA's have report at shift change in which the assistance a resident required is communicated. Continued interview confirmed a CNA could also utilize the Nurse Aide Communication Card in a resident's closet to obtain the information. Further interview with LPN #4 confirmed if neither is available then the CNA should check with the nurse to confirm how much assistance a resident needed. Continued interview confirmed each resident .usually has . a Nurse Aide Communication Card in the resident's closet. Interview with CNA #5 on August 13, 2014, at 10:06 a.m., in the 100 Hallway, confirmed not every resident has a Nurse Aide Communication Card in their closets. Continued interview confirmed if the CNA does not know the level of assistance a resident required then the CNA would ask another CNA or nurse. Further interview confirmed the information is also passed on in CNA report at shift change. Interview with CNA #1 on August 13, 2014, at 12:50 p.m., by phone, revealed the CNA was providing personal care to resident #4 on March 25, 2014, in the resident's room. Continued interview with CNA #1 revealed the CNA .went in to change (resident).laying on back, changed (resident) turned pad and rolled toward window, laid (resident) back down and ready to turn toward door and heard 'pop'.didn't know anything was wrong until turned (resident) back on (resident's) back and saw abnormality. Further interview with CNA #1 confirmed the CNA had repositioned the resident alone, .there was nobody with me. Continued interview with the CNA revealed, .(resident) was able to assist some., and CNA #1 confirmed the CNA had .turned the resident all the time. without help from another CNA. Further interview confirmed the CNA would .just go ahead and do it.had to have two people to get

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 0323 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) (resident) out of bed but (resident) was an easy turn. Continued interview revealed the CNA was aware of how much assistance a resident required .it would be on (resident's) chart or we know if resident makes a motion that resident can assist and will use one person. Interview with the Administrator and Director of Nursing (DON) on August 13, 2014, at 1:15 p.m., in the Training Room, confirmed the resident was assessed as requiring the assist of two plus staff for bed mobility. Continued interview with the Administrator and DON confirmed the resident was repositioned in the bed with the assistance of only one staff, and confirmed the resident was harmed as a result of the facility's failure to provide the assistance of two staff members to prevent injury to the resident during repositioning. Complaint #