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

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC #1	445123	A. BUILDING ______ B. WING ______	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXIAN VILLAGE OF TENNESSEE	671 ALEXIAN WAY SIGNAL MOUNTAIN, TN 37377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Investigation of Complaint (C/O) #30155 and #28635 was conducted at the facility on February 12-15, 2013, and February 19-21, 2013. No deficiencies were cited for C/O #28635. Medical record review and interview during the investigation of the C/O #30155 resulted in an Immediate Jeopardy cited for neglect and failure to provide supervision and safe assistance when turning a resident. A partial extended survey was conducted on February 21, 2013. The Administrator and Director of Nursing were informed of the Immediate Jeopardy in the Conference Room on February 20, 2013, at 2:15 p.m. The Immediate Jeopardy was effective from July 9, 2012, through February 20, 2013. Substandard Quality of Care was cited under F323, at a scope and severity level of "J." An Acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received and corrective actions were validated on-site by the surveyor on February 21, 2013. Non-compliance of the Immediate Jeopardy tags continues at a scope and severity of a "D" level for monitoring of corrective actions. The facility is required to submit a plan of correction for all tags.	F 000	Alexian Village of Tennessee Healthcare and Rehabilitation Center offers this Plan of Correction as its allegation of compliance with the participation requirements for long term care facilities and as evidence of its ongoing efforts to provide quality care to residents. Disclaimer Statement Alexian Village of Tennessee Healthcare and Rehabilitation Center does not admit that any deficiencies existed, before, during or after the survey. Alexian Village of Tennessee Healthcare and Rehabilitation Center reserves all rights to contest the survey findings through the IDR, formal appeal proceeding, or any administrative or legal proceedings. This POC is not meant to establish any standard of care or contractual obligation and Alexian Village of Tennessee Healthcare and Rehabilitation Center reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this POC should be deemed applicable to peer review, quality assurance, or self-critical examination privileges, which Alexian Village of Tennessee Healthcare and Rehabilitation Center does not waive. F 282, §483.20(k)(3)(ii), SERVICES BY QUALIFIED PERSONS/PER CARE PLAN Resident #1 expired July 9, 2012. The facility conducted a Root Cause Analysis on July 12, 2012. Recommended actions were reviewed and implemented on July 17, 2012. Actions have been taken to ensure that staff is aware of and complies with each resident's individualized plan of care. (continued next page)	
F 282 SS=J	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility	F 282		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: CEO & INTERIM ADMINISTRATOR (X6) DATE: 03/13/13

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 282	Continued From page 1 must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility investigation, review of facility in-service, review of facility policy, and interview, the facility failed to follow the resident's individualized care plan, and provide the required level of assistance to prevent a fall for one resident (#1) of eight residents reviewed. The facility's failure to ensure resident #1's care plan was followed and the required safe assistance was provided when turning the bedridden resident resulted in a fall from the bed with multiple bodily injuries and sudden death on July 9, 2012. The facility's failure placed resident #1 in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment or death). The Administrator and Chief Nursing Officer were informed of the Immediate Jeopardy in the Conference Room on February 20, 2013, at 1:35 p.m. The findings included: Resident #1 was admitted to the facility on April 7, 2008, and readmitted on December 8, 2011, with diagnoses including Morbid Obesity; Chronic Obstructive Pulmonary Disease; Dyspnea;	F 282	Residents requiring the assistance of two persons for bed mobility have been, and will continue to be, identified through nursing assessments and through the examination of MDSs and Care Plans. Identified residents have been, and will continue to be, entered into the Electronic Activities of Daily Living (EADL)/Kardex/Care Plan systems to cue staff to resident needs. Director of Nursing or designee(s) have provided education for the nursing staff related to recognition of residents requiring the assistance of two persons for bed mobility, compliance with the resident care plan, proper techniques for turning and positioning the residents, and the required reporting of any noncompliance. The nursing staff was educated by July 19, 2012 concerning the proper assessment of residents for required assistance with turning and the entry of accurate and consistent information in the Kardex/Care Plan/MDS systems (documentation of staff attendance was incomplete; therefore, repeat in-service training was conducted and fully documented on February 20, 2013). Care Tracker resident profiles were updated on July 23, 2012 to include the number of staff required to assist with bed mobility. Director of Nursing or designee(s) have provided education for the nursing staff related to recognition of residents requiring the assistance of two persons for bed mobility, compliance with the resident care plan, proper techniques for turning and positioning the residents, and the required reporting of any noncompliance. The facility staff member involved with Resident #1's care was promptly counseled regarding required compliance with the Kardex/Care Plan/MDS systems and the proper turning/transfer technique. This staff member was subsequently suspended. RN#1 was counseled regarding the need to immediately report and correct staff non-compliance with resident's plan of care and subsequently was suspended and required to take an online course regarding supervisory skills. The Director of Nursing or designee(s) will conduct weekly checks for 30 days to ensure accuracy and consistency of the Kardex/Care Plan/MDS entries, the CNAs' documentation in the EADL, and will visually observe and interview nursing staff to monitor	

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F 282	Continued From page 2 dependent oxygen supplement; Acute Cor Pulmonale; Heart Failure; Chronic Kidney Disease; Chronic Anemia; Hypertension; Noninfectious Lymphedema; and Degenerative Joint Disease. Medical record review of an Advanced Directive for Health Care, dated February 11, 2011, signed by the resident (as declared by two different witnesses), revealed, "...I, (resident), have made this document to set forth my treatment instructions...in case of my incapacity. As a student of the Holy Scriptures I direct that NO TRANSFUSIONS of whole blood, red cells, white cells, platelets, or plasma be given me under any circumstances, even if the health care providers believe that such are necessary to preserve my life...I give no one...any authority to disregard or override my instructions set forth herein. Family members, relatives, or friends may disagree with me, but any such disagreement does not diminish the strength or substance of my refusal of blood or other instructions..." Medical record review of a hospital History and Physical dated December 5, 2011, revealed the resident was transferred and admitted to the hospital and treated for Respiratory Failure. Medical record review of a Physician's Progress Note dated December 8, 2011, at 3:52 p.m., revealed the resident was discharged from the hospital back to the nursing home on December 8, 2011. Continued review of a Physician's Progress Note dated December 9, 2011, revealed the resident stated to have "contemplated long and has come to a decision after discussion with friends, counselor, brother, social worker, and	F 282	compliance. The Director of Nursing or designee(s) will report findings to the QAA Committee and the CEO of the facility. Based on these findings, the QAA Committee, together with the CEO, will determine whether any additional corrective actions, and additional monitoring is required, and assure implementation of the same. The CEO will report on compliance with the Plan of Correction to the Board of Directors (the "Quality Council"), which has oversight responsibilities for quality resident services and for assurance of compliance with regulations and standards of governmental organizations.	03/08/13

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F 282	Continued From page 3 after (resident's) care plan meeting with (nursing home) staff. (Resident) wishes for...goals to be changed to 'DNR (Do Not Resuscitate)-Comfort Care.' (Resident) does not wish to be transferred to the hospital for life-threatening conditions...wants us (nursing home) to treat...pain and anxiety and have (a) goal of 'comfort' as foremost." Medical record review of Physician Orders for Scope of Treatment (POST), dated December 9, 2011, signed by the resident and treating physician, revealed the resident was a DNR, with comfort measures. "Other instructions" on the POST revealed, "DO NOT HOSPITALIZE." Medical record review of a Significant Change in Status Minimum Data Set (MDS), dated December 14, 2011, revealed a cognition score of thirteen (thirteen-fifteen cognitively intact). Continued review revealed the resident was totally dependent and required the physical assistance of two or more staff for bed mobility and toilet use. The resident's weight measured 429 pounds. Medical record review of the Resident Kardex (Certified Nursing Assistant (CNA) care plan), dated December 8, 2011, revealed, "...The following interventions are to be provided to the resident as a part of his/her individual plan of care...Toileting (Please Circle)..." Continued review revealed the required circled intervention for toileting (still current at the time of the fall) was "Assist of 2 (two staff)." Medical record review of the MDS's dated March 8, 2012, and May 30, 2012, revealed the	F 282		

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F 282	Continued From page 4 resident's cognition had improved to a score of fifteen but; remained totally dependent and continued to require the physical assistance of two or more staff. The resident's body weight revealed 469 pounds and 476 pounds, respectively. Medical record review of the Physician's Recapitulation Orders, dated July 1 through July 31, 2012, revealed, "...Aranesp (stimulates the production of red blood cells for chronic kidney disease-associated anemia), inject...200 mcg (micrograms), sub-q (subcutaneous; under the skin), every week..." Continued review revealed the resident's hemoglobin (a lab test to determine the blood's ability to carry oxygen throughout the body) was to be obtained routinely, every week. If the hemoglobin was equal to, or greater than ten, the Aranesp was to be held. Medical record review of the hemoglobin tests obtained January 9, 2012, through July 2, 2012, revealed hemoglobin levels ranged from 7.8 to 9.1 (normal range 12.0-16.0). Review of a facility investigation dated July 9, 2012, revealed, at approximately 6:00 a.m., the resident "fell off the bed during am (a.m.) care." The "Type of Injury" section with check boxes had the following injuries checked, "...abrasion (scraped)...bruise...laceration (cut)...pain...other." The documentation after "other" included "neurochecks." The resident's reported pain was ten, on a scale of one-to-ten, with ten being the worse. Continued review revealed, "...res (resident) lost grip of side rails and continued momentum over the side of the bed..." Review of a Root Cause Analysis (no date)	F 282		

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F 282	Continued From page 5	F 282		

revealed, "...What steps...contributed to...the event? Associate usually performed this duty alone...What human factors were relevant to the outcome? One CNA assisting the resident during rounds. Resident stated that '(CNA #1) moves me kind of fast'...Are there any other factors that have directly influenced this outcome? Resident's wt (weight) was 430# (pounds)..."

Review of a written witness statement dated July 9, 2012, by (CNA #1), revealed, "...I went to change (resident) for morning rounds before I would leave. Told (resident) to lift (resident's) hip to turn (resident). I took and push (pushed) (resident) to (resident's) side. Then before I knew it (resident) was going over. I try (tried) to stop (resident) but (resident) kept on going over and it was to (too) late..."

Review of a written witness statement dated July 9, 2012, by Registered Nurse (RN) #1, revealed, "...'As told by res after the fall'...(CNA #1) was drying me. (CNA #1) moves and turns me kinda (kind of) fast. As (CNA #1) was turning me and I was holding onto the rail (side rail). My hand slipped off the rail. Because I was already moving I fell off the bed. I hit my head. I know my leg hit something because I had a lot (a lot) of pain to my leg, the right one (right leg)..."

Medical record review of a Nursing Progress Note dated July 9, 2010 (2012), by RN #1 revealed the following:

610 (6:10 a.m.), "I was alerted to a 'big problem on 6th (sixth) floor.' I arrived to the 6th floor to observe (resident) laying on the floor of (resident's) room. Floor was wet with liquid cl

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F 282	Continued From page 6 (clear)/yellow and some red. Res (resident's) L (left) thigh was lying on top of (roommate's) bedside table. Table was removed for resident's comfort. Res is alert x (times) 3 (three) but very anxious...called (Local) Fire Depart (department) to assist with moving (resident) up off the floor. I called (physician)...to let (physician) know of 3-4 (three-to-four) inch laceration to R (right) lateral calf and res refusal to go to hospital. Res neurological intact during assmt (assessment). While waiting for (fire department) lac (laceration) to RLE (right lower extremity) cleaned & (and) dressed." 630 (6:30 a.m.), "1st (first) EMS (Emergency Medical Services) crew arrived-they called a 2nd (second) crew in to help with lifting the res up." 715p (7:15 a.m.), "Res rolled onto tarp and lifted to bed c (with) assist (assistance) of 10 (ten). Res positioned in bed. Tarp removed." 740 (7:40 a.m.), "Bath given to res. Large bruise noted to R thigh, abrasion & bruise noted to R elbow & RFA (right forearm). Abrasion noted to ABD (abdomen). Absion (abrasion) & bruis (bruise) to R hip/buttock (hip and buttock) area-Abrasion noted to L lateral torso (the part of the body to which the head, arms, and legs are attached)...to axilla...3-4 (three-to-four) laceration to RLE laterally. Lac cleaned & covered c exerform (xeroform; gauze), ABD pad & wrapped c Kerlix (gauze roll)..." 815 (8:15 a.m.), "Spoke with (Physician office)...bringing a suture kit...(physician) will be here about 9A (9:00 a.m.)."	F 282		

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F 282	Continued From page 7 Medical record review of a lab report dated July 9, 2012, revealed the routine weekly hemoglobin was collected at 8:40 a.m. Medical record review of a Physician's Progress Note dated July 9, 2012, revealed the resident had a fall in the early morning. Injuries included bruises to the right thigh; a three and one-half to four inch laceration on the right lateral lower extremity; numerous abrasions on the shoulder (right or left not identified), axillary region (right or left not identified), abdomen, and right hip. The resident was complaining of pain in the thigh (right or left not identified), and revealed, "I cannot move my leg." The resident complained of nausea and retching (unproductive effort to vomit); and was anxious due to the fall and laceration. The laceration was cleaned, locally (edges of the laceration) anaesthetized (numbed), and eight sutures were placed. Medical record review of the Physician's Telephone Orders dated July 9, 2012, revealed the following orders: 1. X-ray of the right thigh, leg, and foot; 2. Clean incision (laceration) on right leg daily with normal saline; apply kerlix and xeroform dressing daily and PRN (as needed); 3. Augmentin (antibiotic), 500 milligrams, by mouth, three times daily for five days. Medical record review of the Medication Administration Record, dated July 1 through July 31, 2012, revealed the following: 1. The laceration was cleaned and dressed as ordered, for wound care;	F 282		

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F 282	Continued From page 8 2. Ativan, 0.5 milligrams, was administered by mouth, at 6:45 a.m., for anxiety; 3. Augmentin was started (at 8:00 a.m.), for prevention of infection; 4. Hydrocodone/Acetaminophen, 5 milligrams-325 milligrams, was administered by mouth, at 8:00 a.m., for pain. Medical record review of the X-ray reports dated July 9, 2012, at 1:00 p.m., revealed two radiologic reviews (x-rays) of the right femur, right tibia and fibula, and the right foot, with the following impressions: 1. Femur, "...no gross (visible) acute displaced fractures..." 2. Tibia and fibula, "...no acute displaced fractures..." 3. Foot, "...no gross acute fractures of the foot...Prominent soft tissue swelling..." Medical record review of a routine weekly hemoglobin lab report dated July 9, 2012, collected at 8:40 a.m., revealed a result of 6.4, which was a 2.3 drop from the previous hemoglobin of 8.7 obtained on July 2, 2012. Medical record review of a Physician's Telephone Order dated July 9, 2012, at 4:00 p.m., revealed orders for a Stat (immediately) repeat of the hemoglobin and to call the Physician with the results. Medical record review of a Nursing Progress Note dated July 9, 2012, at 11:15 p.m., revealed, "...Rcvd (received) call from (hospital) lab...critical value...(hemoglobin)...4.6...Observed res at that time non responsive, resp (respiration) was	F 282		

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F 282	Continued From page 9 observable. Called family...to notify...this occurred at 8:10 p.m. Difficult to obtain vs (vital signs), b/p (blood pressure) 66/40, pulse 51. LM (left message) with answering service for MD (Medical Doctor). Re: (regarding)...hemoglobin. CNA called for the nurse 8:20 p.m., to observe 0 (no) resp. Supervisor called to room. Family arrived in facility approx (approximately) 9:50 p.m. & was made aware of res passing..." Medical record review of a lab report dated July 9, 2012, revealed the repeat hemoglobin result was 4.6, which was a further drop of 1.8 from the previous hemoglobin of 6.4 obtained earlier at 8:40 a.m. Medical record review of the Record of Death revealed the 66 year old resident's date and time of death were on July 9, 2012, at 8:25 p.m. The immediate cause of death revealed, "Sudden death due to questionable internal bleeding secondary to fall." Review of facility in-service, ADL (Activities of Daily Living) Assistance and Kardex, dated November 23 through November 30, 2011, revealed, "...Explained the ADL coding...what each care level meant in the terms of type of assistance provided and the amount of staff needed for the assistance...Explained the new kardex system. Instead of looking in the care plan book a Kardex notebook will be located at each nurse's station for each hall...The Kardex book will contain an information sheet on each resident to provide the level of assistance needed in ADL's...check this book prior to assisting any resident. This will begin December 1, (2011)..."	F 282		

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F 282	Continued From page 10 Review of facility policy, "Comprehensive Care Plan," dated August 2001, revealed, "Purpose: Each resident's ...care plan has been designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems...e. Identify...services that are responsible for each element of care; f. Aid in preventing or reducing (resident) declines...Policy: An individualized...care plan...to meet the resident's medical, nursing, mental and psychological needs...for each resident..." Interview with CNA #1 on February 12, 2013, at 5:30 p.m., in the conference room, confirmed, "...I went into the resident's (#1) room to change (provide incontinence care)...(resident) just before the end of the shift. (Resident) was a big woman and I had to take both of my hands and push (resident) hard, with a lot of force, because resident was so big." As CNA #1 described "pushing" the resident, CNA #1 held both hands up, and with the palms of both hands facing forward, demonstrated a pushing gesture using both hands. "I didn't ask anybody to help me...I did it by myself (turned the resident)...When I pushed (resident) over, I couldn't see the opposite side of (resident) because (resident) was so big...when (resident) was turned, (resident) went over so hard and fast, I couldn't stop (resident)...As (resident) went over, (resident) hit (resident's) head on the night stand...there was a huge knot on her forehead (CNA #1 reached up and touched the right side of CNA #1's forehead)...I think the right side of (resident's) forehead...(resident) landed on the bottom (metal base of the table) of the over-the-bed table...there was blood on the floor from a gash on (resident's) right lower leg, and it	F 282		

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

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445123	A. BUILDING ______ B. WING ______	C 02/21/2013

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F 282	Continued From page 11 was (resident's) bad leg...the one that hurt (resident) all the time. I should have had someone helping me. Before I went out to get help, I made sure (resident) was breathing. (CNA #5) was in a nearby room...I hollered (called out loud) '(CNA #5)!'...because I knew (CNA #5) wasn't far from me...(CNA #5) came in and I stayed with (resident) while (CNA #5) went to get the nurse...(RN #1), Licensed Practical Nurse (LPN #3), (CNA #5), and myself were looking at (resident) trying to figure out how we were going to get (resident) off of the over-the-bed table... (RN #1), (CNA #5), and me pulled (resident) over as (LPN #3) pulled the over-the-bed table from under (resident)...We were talking to (resident)... (resident) was in pain...(LPN #3) got (resident) some Ativan to help (resident) calm down... (resident) said (resident) couldn't breathe...I guess it was an anxiety attack...(resident) calmed down with the Ativan...(Physician) told me it was an accident that ended bad...I was responsible...I pushed (resident) over...I couldn't see that (resident) had lost (resident's) hand grip...I couldn't see (resident's) hand...(resident) was so big..." Continued interview revealed CNA #1 denied knowing the resident required the assistance of two for toileting and "Nobody in-serviced (educated) me or gave me any disciplinary action." Interview with Resident Assessment Information Coordinator (RAIC) #1 on February 13, 2013, at 10:30 a.m., in the conference room, confirmed the resident was a total assist with turning, toileting, and transferring, and required the assistance of two or more staff. "The information was on the care plan and the kardex (a reference for resident-specific information related to nursing	F 282		

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

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 12 care); and the kardex is a CNA-based care plan. All CNA's were trained and required to use the kardex for resident specific information." RAIC #1 confirmed, "The resident's care plan identified the resident required total assistance with two staff for toileting. On July 9, 2012, at 6:00 a.m., one CNA (#1) was assisting the resident with toileting, and the resident fell from the bed." RAIC #1 confirmed the facility failed to ensure the resident's individualized care plan was followed, and provide the required and safe assistance of two staff. Interview with RAIC #2 on February 13, 2013, at 12:15 p.m., in the conference room, confirmed, "...I completed (resident's) Significant Change in Status MDS, on December 14, 2011, and MDS assessment on May 30, 2012...(resident) was totally dependent. I updated the care plan and kardex on December 8, 2011, to include interventions for toileting with the assist of two. All care plans are developed, and updated according to each resident's assessment and any change in condition. The resident's information is, and was during this resident's stay, maintained in the care plan binders at each nurse's station...the kardex was also being used at that time, and was located at each nurse's station. In just looking at the resident's size, common sense would tell you it would take two, at least, to change, clean, and turn (resident). It was not safe for (resident) to be assisted by one CNA...We have switched to an electronic system with a kiosk (free-standing computer station and display screen) located on each hallway for the CNA's to reference for each resident's specific care and assistance." Continued interview confirmed, "When (CNA #1) assisted the resident	F 282		

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

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 13 by (CNA #1's) self, with toileting (on July 9, 2012, at 6:00 a.m.), the care plan was not followed and (resident) fell from the bed." RAIC #2 confirmed the facility failed to follow the resident's care plan. Interview with RN #1 on February 13, 2013, at 11:15 a.m., in the conference room, confirmed, "On the morning of July 9, 2012, I was called (RN #1 was on seventh floor; resident was on sixth floor), and told that (resident) was on the floor, and had fell from the bed. I assessed (resident's) neurological status...was alert, and oriented x3 (to person, place, time)...no neurological distress or changes. There was bloody fluid in the floor...was a cut on the (resident's) leg that was bleeding...right lateral calf (side area between knee and ankle)...The fire department was notified for assistance." RN #1 reviewed the Nursing Progress Notes and witness statement, written by RN #1, and confirmed the following injuries were observed by RN #1 from the resident's fall: 1. Left lateral torso-abrasion going into the axilla (armpit); 2. Abdomen-(belly)-abrasion; 3. Right hip and buttock area-abrasion and bruising; 4. Right lateral lower extremity (leg)-three-to-four lacerations; 5. Right thigh (upper leg), anterior (front)-large bruise; 6. Right elbow and forearm (part of arm between elbow and hand)-large bruise; 7. Right lateral calf-three-to-four inch laceration Continued interview with RN #1 confirmed RN #1 was aware the resident was a total assist and	F 282		

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

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 14 defined "total assist" as "required the assist of two or more staff." RN #1 confirmed to have observed only one CNA providing assistance to the resident, prior to the resident's fall. "I have seen one CNA assisting the resident...The CNA's knew not to provide ADL's with one CNA...but some did...It was not safe for the resident to be assisted by only one CNA..." Continued interview with RN #1 confirmed, "I did not report the CNA's non-compliance with the resident's required assistance to the Chief Nursing Officer (CNO), or Administrator...I didn't report it to anyone...I didn't do any disciplinary action or in-servicing was provided in response to the CNA's who were non-compliant with the resident's required assistance of two..." RN #1 confirmed the facility failed to ensure the resident received supervision and assistance to prevent the fall on July 9, 2012. Interview with the Physician on February 13, 2013, at 2:30 p.m., in the conference room, confirmed the Physician had completed a Fellowship in Geriatric Medicine, and had provided Physician services to the resident for over one and one-half years. "The resident was chronically anemic secondary to Chronic Kidney Disease, and was being treated with Aranesp, which required routine weekly monitoring of the resident's hemoglobin. The resident's hemoglobin historically ranged between 8.0-9.0; with one occasion of a false-low. On (July 9, 2012), the day of the fall, (resident) had a routine hemoglobin, which came back critically low, with a result of 6.4. Due to the previous false-low, I ordered a Stat repeat (of the hemoglobin). The repeat (blood specimen) was difficult for the nurses to obtain from the resident, but once successfully obtained, the result remained	F 282		

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

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 15 critically low...even lower at 4.6. I discussed (resident's) Advanced Directives with (resident). (Resident) refused to go to the hospital after the fall, and continued to refuse to go with the critically low hemoglobin results...This drop in the hemoglobin indicated internal bleeding...There is normally not a 'two-point drop' in an approximate ten-hour period; there would have to be a significant bleed for that much of a drop (in the hemoglobin)...With the resident's size, the bleed was not obvious..." Continued interview with the Physician confirmed, "...Due to the resident's obese and debilitated condition, it was not safe to turn or clean (resident) with one CNA; at least two were needed. While the resident was comorbidly obese...this accident (fall) was separate from (resident's) disease processes. The immediate cause of (resident's) death was due to the accident, not (resident's) diagnoses." Interview with CNA #4 on February 13, 2013, at 3:50 p.m., in the conference room, confirmed, "I routinely cared for (resident) and periodically, I reviewed the (resident's) care plan and kardex...I knew the resident was a total assist with two people, to turn and clean; but there were days I did it by myself, and there were days I got other CNA's to help with (resident)..." Interview with CNA #5 on February 13, 2013, at 3:50 p.m., in the conference room, confirmed, "...I knew (resident was a two-person assist...I knew it was not safe to do (resident) by myself but, I did. If (resident's) bed needed changing, I always got another person to help because you would not be able to reach across the bed; it was too big and you would run yourself to death going from side-to-side. It was quicker if two did it (changed	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 16 the bed). We had the kardex and care plan...I knew it took two people but I just thought I could get it done by myself and move on. Continued interview with CNA #5 confirmed, "On the morning of the fall (July 9, 2012), I was in a room beside of (resident's) room...I heard the loudest noise and I thought, 'God, I hope nobody fell out of bed.' About that time, (CNA #1) came rushing through the door (where CNA #5 was)...screaming, '(CNA #5)! (Resident) fell out of bed!' (Resident) was on the floor; (CNA #1) stayed with (resident) while I got help...I called upstairs and said, 'We need somebody down here now! We've got a resident in an incident and need somebody NOW!' (Resident) looked pitiful lying there. (RN #1) came down. EMS and the fire department responded to the call for help. The fire department had to help us get (resident) up...we got (resident) onto a bed pad and little-by-little, we were able to get (resident) onto a floor mat. Once on the mat, at least ten firemen, maybe more, lifted the resident to the bed. (Resident's) leg was messed up...cut...there was blood...we just had to get (resident) up...it was awful...it was pitiful." Interview with RN #2 on February 13, 2013, at 8:00 p.m., in the conference room, confirmed RN #2 routinely provided the care and services, and supervision of (resident). "(Resident) went 'down-hill' in 2011...had declined and required the assistance of two people. I was quite surprised...shocked...when I found out (resident) had fallen (on July 9, 2012), when only one CNA had attempted to assist (resident) with care. I didn't realize or even think it could be done, and obviously, it shouldn't have. Continued interview with RN #1 confirmed, "It was not safe for one to	F 282		

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

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 17	F 282		

assist (resident) in turning, incontinence care...the potential for harm was so much greater."

Interview by telephone with RN #3 on February 14, 2013, at 12:52 p.m., confirmed, "I was the previous CNO, at the time of (resident's) fall (on July 9, 2012). (Resident) was a two-person assist with turning and incontinence care and (resident's) assist level was on the kardex...'assist of two.' I recall this because it was a very serious event...we investigated it thoroughly..." Continued interview with RN #3 confirmed no one, to include (RN #1), had reported observing any CNA's who were non-compliant regarding using the required assistance with (resident). "The facility neglected to provide the care the resident needed."

Interview by telephone with LPN #3 on February 14, 2013, at 6:42 p.m., confirmed LPN #3 provided assistance to the resident and nursing staff, after the resident's fall from the bed on July 9, 2012. (Resident's) leg was bleeding badly... (resident) was in a lot of pain and was anxious. (Resident) refused to go to the hospital...I gave (resident) anxiety and pain medication, and it helped...(resident) calmed down and slept. As the day went on, (resident) declined...it was a steady decline from the point of the fall until (resident) died. (Resident) was a two-person assist. This was all because the CNA (#1) failed to obtain the assistance of another person; and used the inappropriate turning technique, by turning (resident) in the opposite direction of the CNA (#1) (instead of toward CNA #1)..."

A second interview with CNA #1 on February 15, 2013, at 12:15 p.m., in the conference room,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 18 confirmed, "I was 'blurry' in my recall of the incident with assisting (resident) with incontinence care on July 9, 2012. I've had time to think about it, and my memory is now clear. I was trained in orientation to use the kardex to find the care and assist needs the residents' needed, including (resident). I was trained to always turn the resident toward me, never to turn away from me. I knew (resident) was needed the assist of two people...I just felt like I could do (resident) by myself. There was staff here to help me, and they would have if I had asked them; but I just didn't ask them. When I was changing (resident) (on July 9, 2012), (resident) was too big for me to pull (resident) to me. I had to push (resident) to get (resident) over and to be on the side where (resident's) bottom was to clean it. When I pushed (resident) over, I took my hands off of (resident) to get the brief ready; then I proceeded to clean (resident). It was at this point I noticed (resident) was going over (falling out of the bed). (Resident) was in an over-sized bed and it was impossible for me to get around the bed to break (resident's) fall. (Resident) was too big for me to see over (resident's) body and see that (resident's) hand was not on the side rail. Continued interview with CNA #1 confirmed, "I was never meaning to lie to you about this. It has been seven months and I had to re-think it. I was caught off-guard when I talked to you Tuesday night (February 12, 2013). I've had time to think about it and I wanted to clear this up." Interview with the CNO on February 15, 2013, at 2:00 p.m., in the conference room, confirmed the CNO began working for the facility in 1998, and has since held various positions, to include: MDS Coordinator, Quality Assurance Coordinator,	F 282		

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

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 19 Quality Assurance Director; and most current, CNO. "I personally trained (CNA #1) on using the kardex in November of 2011." Continued interview with the CNO confirmed, "I was the Quality Assurance Director at the time of the resident's fall (on July 9, 2012). I was aware of the fall and completed a root-cause analysis, which identified (CNA #1) failed to ensure the assist of two people when turning and providing incontinence care to the resident. (RN #1) was required to ensure any nursing staff who failed to provide the assistance required for (resident) was disciplined; and was required to ensure reporting of the non-compliance to administration (CNO especially), to ensure education and follow-up...this did not happen..." The CNO confirmed the facility failed to provide the required supervision and assistance to prevent (resident's) fall on July 9, 2012. Interview with the Administrator on February 20, 2013, at 2:00 p.m., in the conference room, confirmed (Administrator) had been made aware of the resident's fall at approximately 7:00 a.m., on July 9, 2012, (approximately one-hour after the fall). "Through investigation initiated upon the fall, the facility confirmed, the resident was provided incontinence care by one CNA (#1), instead of two CNA's, as required for the safety of the resident. (RN #1) was the 'house supervisor' on July 9, 2012. (RN #1) was responsible for the general oversight of the nursing department on (RN #1's) shift. (RN #1) did not report (to the Administrator) any CNA's being non-compliant with providing the resident the required assistance to ensure the safety of the resident..." Continued interview confirmed, "(CNA #1) failed to provide the correct turning technique and failed	F 282		

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

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

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F 282	Continued From page 20 to provide the correct amount of assistance required for (resident) and the resident fell from the bed (on July 9, 2012). (RN #1) failed to ensure the required supervision to ensure the safety of (resident). The Administrator confirmed the facility failed to ensure (resident #1) received the required supervision and assistance to prevent the fall on July 9, 2012. In summary, CNA #1, failed to follow the resident's care plan and obtain the required assistance when turning and attempting to provide incontinence care to the resident, resulting in a fall with injury from the bed on July 9, 2012, at 6:00 a.m. The Immediate Jeopardy was effective from July 9, 2012, through February 20, 2013, and was removed on February 20, 2013. An Acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received and corrective actions were validated by the surveyor through review of documents, staff interviews, and observations conducted onsite on February 21, 2013. The surveyor verified the corrective actions by: 1. Reviewing the facility's in-service records to ensure all nursing staff had been educated on neglect, assistance with ADL's, turning and positioning a resident, and non-compliance with assistance levels; 2. Reviewing the facility's in-service records to ensure all nursing staff knew where the residents' care plans are and how to use them; 3. Reviewing the facility's in-service records to	F 282		

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ALEXIAN VILLAGE OF TENNESSEE	671 ALEXIAN WAY SIGNAL MOUNTAIN, TN 37377

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F 282	Continued From page 21 ensure all CNA staff had been educated on the electronic care plan system; 4. Reviewing the facility's in-service records to ensure all licensed nursing staff had been educated on and the implementation of the facility's policy and procedure on "Special Handling and Movement Challenges related to Bariatrics;" 5. Reviewing the corrective actions implemented for the non-compliant staff, (RN #1, CNA's #1, #4, and #5) 6. Conducting interviews with eight of nineteen licensed nursing staff employed to determine the level of comprehension gained through in-service education conducted regarding facility policies on neglect, assistance with ADL's, turning and positioning a resident, care plans, non-compliance with, (a) the supervision of resident care, and (b) assistance levels; 7. Conducting interviews with nineteen of forty-four CNA staff employed to determine the level of comprehension gained through in-service education conducted regarding facility policies on assistance with neglect, ADL's, turning and positioning a resident, care plans, and non-compliance with required assistance levels; 8. Conducting interviews and observations of seven CNA's regarding the use of the electronic care plan system; 9. Observing the level of assistance CNA's provided to five residents requiring the assistance of two, in accordance with the resident's care plan	F 282		

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

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445123	A. BUILDING ______ B. WING ______	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXIAN VILLAGE OF TENNESSEE	671 ALEXIAN WAY . SIGNAL MOUNTAIN, TN 37377

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F 282	Continued From page 22 and electronic care plan system; Non-compliance continues at a "D" level for monitoring corrective actions. C/O #30155	F 282		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility investigation, review of facility in-service, and interview, the facility failed to provide supervision and safe assistance to prevent a fall for one resident (#1) of eight residents reviewed. The facility's failure to ensure resident #1 was supervised and safe assistance was provided when turning the bedridden resident resulted in a fall from the bed with multiple bodily injuries and sudden death on July 9, 2012. The facility's failure placed resident #1 in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment or death). The Administrator and Chief Nursing Officer were	F 323	F 323, §483.25(h), FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES Resident #1 expired July 9, 2012. The facility conducted a Root Cause Analysis on July 12, 2012. Recommended actions were reviewed and implemented on July 17, 2012. The facility has ensured the resident environment remains free of hazards as reasonably possible and each resident received supervision and assistance devices to prevent accidents. Residents requiring the assistance of two persons for bed mobility have been, and will continue to be, identified through nursing assessments and through the examination of MDSs and Care Plans. Identified residents have been, and will continue to be, entered into the Electronic Activities of Daily Living (EADL)/Kardex/Care Plan systems to cue staff to resident needs. Director of Nursing or designee(s) have provided education for the nursing staff related to recognition of residents requiring the assistance of two persons for bed mobility, compliance with the resident care plan, proper techniques for turning and positioning the residents, and the required reporting of any noncompliance. The nursing staff was educated by July 19, 2012 concerning the proper assessment of residents for required assistance with turning and the entry of accurate and consistent information in the Kardex/Care Plan/MDS systems (documentation of staff attendance was incomplete; therefore, repeat in-service training was conducted and fully documented on February 20, 2013). (continued next page) Care Tracker resident profiles were updated on July 23, 2012 to include the number of staff required to assist with bed mobility. Director of Nursing or designee(s) have provided education for the nursing staff related to recognition of residents requiring the assistance of two persons for bed mobility, compliance with the resident care plan, proper techniques for turning and positioning	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445123	A. BUILDING ______ B. WING ______	C 02/21/2013

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ALEXIAN VILLAGE OF TENNESSEE	671 ALEXIAN WAY SIGNAL MOUNTAIN, TN 37377

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F 323	Continued From page 23 informed of the Immediate Jeopardy in the Conference Room on February 20, 2013, at 1:35 p.m. Substandard Quality of Care was cited under tag F-323 at a scope and severity level of a "J." The findings included: Resident #1 was admitted to the facility on April 7, 2008, and readmitted on December 8, 2011, with diagnoses including Morbid Obesity; Chronic Obstructive Pulmonary Disease; Dyspnea; dependent oxygen supplement; Acute Cor Pulmonale; Heart Failure; Chronic Kidney Disease; Chronic Anemia; Hypertension; Noninfectious Lymphedema; and Degenerative Joint Disease. Medical record review of an Advanced Directive for Health Care, dated February 11, 2011, signed by the resident (as declared by two different witnesses), revealed, "...I, (resident), have made this document to set forth my treatment instructions...in case of my incapacity. As a student of the Holy Scriptures I direct that NO TRANSFUSIONS of whole blood, red cells, white cells, platelets, or plasma be given me under any circumstances, even if the health care providers believe that such are necessary to preserve my life...I give no one...any authority to disregard or override my instructions set forth herein. Family members, relatives, or friends may disagree with me, but any such disagreement does not diminish the strength or substance of my refusal of blood or other instructions..." Medical record review of a hospital History and	F 323	the residents, and the required reporting of any noncompliance. The facility staff member involved with Resident #1's care was promptly counseled regarding required compliance with the Kardex/Care Plan/MDS systems and the proper turning/transfer technique. This staff member was subsequently suspended. RN#1 was counseled regarding the need to immediately report and correct staff non-compliance with resident's plan of care and subsequently was suspended and required to take an online course regarding supervisory skills. The Director of Nursing or designee(s) will conduct weekly checks for 30 days to ensure accuracy and consistency of the Kardex/Care Plan/MDS entries, the CNAs' documentation in the EADL, and will visually observe and interview nursing staff to monitor compliance. The Director of Nursing or designee(s) will report findings to the QAA Committee and the CEO of the facility. Based on these findings, the QAA Committee, together with the CEO, will determine whether any additional corrective actions, and additional monitoring is required, and assure implementation of the same. The CEO will report on compliance with the Plan of Correction to the Board of Directors (the "Quality Council"), which has oversight responsibilities for quality resident services and for assurance of compliance with regulations and standards of governmental organizations.	03/08/13

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

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 24 Physical dated December 5, 2011, revealed the resident was transferred and admitted to the hospital and treated for Respiratory Failure. Medical record review of a Physician's Progress Note dated December 8, 2011, at 3:52 p.m., revealed the resident was discharged from the hospital back to the nursing home on December 8, 2011. Continued review of a Physician's Progress Note dated December 9, 2011, revealed the resident stated to have "contemplated long and has come to a decision after discussion with friends, counselor, brother, social worker, and after (resident's) care plan meeting with (nursing home) staff. (Resident) wishes for...goals to be changed to 'DNR (Do Not Resuscitate)-Comfort Care.' (Resident) does not wish to be transferred to the hospital for life-threatening conditions...wants us (nursing home) to treat...pain and anxiety and have (a) goal of 'comfort' as foremost." Medical record review of Physician Orders for Scope of Treatment (POST), dated December 9, 2011, signed by the resident and treating physician, revealed the resident was a DNR, with comfort measures. "Other instructions" on the POST revealed, "DO NOT HOSPITALIZE." Medical record review of a Significant Change in Status Minimum Data Set (MDS), dated December 14, 2011, revealed a cognition score of thirteen (thirteen-fifteen cognitively intact). Continued review revealed the resident was totally dependent and required the physical assistance of two or more staff for bed mobility and toilet use. The resident's weight measured 429 pounds.	F 323		

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

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 25	F 323		

Medical record review of the Resident Kardex (Certified Nursing Assistant (CNA) Care Plan), dated December 8, 2011, revealed, "...The following interventions are to be provided to the resident as a part of his/her individual plan of care...Toileting (Please Circle)..." Continued review revealed the required circled intervention for toileting (still current at the time of the fall) was "Assist of 2 (two staff)."

Medical record review of the MDS's dated March 8, 2012, and May 30, 2012, revealed the resident's cognition had improved to a score of fifteen but; remained totally dependent and continued to require the physical assistance of two or more staff. The resident's body weight revealed 469 pounds and 476 pounds, respectively.

Medical record review of the Physician's Recapitulation Orders, dated July 1 through July 31, 2012, revealed, "...Aranesp (stimulates the production of red blood cells for chronic kidney disease-associated anemia), inject...200 mcg (micrograms), sub-q (subcutaneous; under the skin), every week..." Continued review revealed the resident's hemoglobin (a lab test to determine the blood's ability to carry oxygen throughout the body) was to be obtained routinely, every week. If the hemoglobin was equal to, or greater than ten, the Aranesp was to be held. Medical record review of the hemoglobin tests obtained January 9, 2012, through July 2, 2012, revealed hemoglobin levels ranged from 7.8 to 9.1 (normal range 12.0-16.0).

Review of a facility investigation dated July 9,

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

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445123	A. BUILDING ______ B. WING ______	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXIAN VILLAGE OF TENNESSEE	671 ALEXIAN WAY SIGNAL MOUNTAIN, TN 37377

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F 323	Continued From page 26 2012, revealed, at approximately 6:00 a.m., the resident "fell off the bed during am (a.m.) care." The "Type of Injury" section with check boxes had the following injuries checked, "...abrasion (scraped)...bruise...laceration (cut)...pain...other." The documentation after "other" included "neurochecks." The resident's reported pain was ten, on a scale of one-to-ten, with ten being the worse. Continued review revealed, "...res (resident) lost grip of side rails and continued momentum over the side of the bed..." Review of a Root Cause Analysis (no date) revealed, "...What steps...contributed to...the event? Associate usually performed this duty alone...What human factors were relevant to the outcome? One CNA assisting the resident during rounds. Resident stated that '(CNA #1) moves me kind of fast'...Are there any other factors that have directly influenced this outcome? Resident's wt (weight) was 430# (pounds)..." Review of a written witness statement dated July 9, 2012, by (CNA #1), revealed, "...I went to change (resident) for morning rounds before I would leave. Told (resident) to lift (resident's) hip to turn (resident). I took and push (pushed) (resident) to (resident's) side. Then before I knew it (resident) was going over. I try (tried) to stop (resident) but (resident) kept on going over and it was to (too) late..." Review of a written witness statement dated July 9, 2012, by Registered Nurse (RN) #1, revealed, "...'As told by res after the fall'...(CNA #1) was drying me. (CNA #1) moves and turns me kinda (kind of) fast. As (CNA #1) was turning me and I was holding onto the rail (side rail). My hand	F 323		

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

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445123	A. BUILDING ______ B. WING ______	C 02/21/2013

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F 323	Continued From page 27 slipped off the rail. Because I was already moving I fell off the bed. I hit my head. I know my leg hit something because I had a lot (a lot) of pain to my leg, the right one (right leg)..." Medical record review of a Nursing Progress Note dated July 9, 2010 (2012), by RN #1 revealed the following: 610 (6:10 a.m.), "I was alerted to a 'big problem on 6th (sixth) floor.' I arrived to the 6th floor to observe (resident) laying on the floor of (resident's) room. Floor was wet with liquid cl (clear)/yellow and some red. Res (resident's) L (left) thigh was lying on top of (roommate's) bedside table. Table was removed for resident's comfort. Res is alert x (times) 3 (three) but very anxious...called (Local) Fire Depart (department) to assist with moving (resident) up off the floor. I called (physician)...to let (physician) know of 3-4 (three-to-four) inch laceration to R (right) lateral calf and res refusal to go to hospital. Res neurological intact during assmt (assessment). While waiting for (fire department) lac (laceration) to RLE (right lower extremity) cleaned & (and) dressed." 630 (6:30 a.m.), "1st (first) EMS (Emergency Medical Services) crew arrived-they called a 2nd (second) crew in to help with lifting the res up." 715p (7:15 a.m.), "Res rolled onto tarp and lifted to bed c (with) assist (assistance) of 10 (ten). Res positioned in bed. Tarp removed." 740 (7:40 a.m.), "Bath given to res. Large bruise noted to R thigh, abrasion & bruise noted to R elbow & RFA (right forearm). Abrasion noted to	F 323		

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

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445123	A. BUILDING ______ B. WING ______	C 02/21/2013

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ALEXIAN VILLAGE OF TENNESSEE	671 ALEXIAN WAY SIGNAL MOUNTAIN, TN 37377

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F 323	Continued From page 28 ABD (abdomen). Absion (abrasion) & bruis (bruise) to R hip/buttock (hip and buttock) area-Abrasion noted to L lateral torso (the part of the body to which the head, arms, and legs are attached)...to axilla...3-4 (three-to-four) laceration to RLE laterally. Lac cleaned & covered c exerform (xeroform; gauze), ABD pad & wrapped c Kerlix (gauze roll)..." 815 (8:15 a.m.), "Spoke with (Physician office)...bringing a suture kit...(physician) will be here about 9A (9:00 a.m.)." Medical record review of a Physician's Progress Note dated July 9, 2012, revealed the resident had a fall in the early morning. Injuries included bruises to the right thigh; a three and one-half to four inch laceration on the right lateral lower extremity; numerous abrasions on the shoulder (right or left not identified), axillary region (right or left not identified), abdomen, and right hip. The resident was complaining of pain in the thigh (right or left not identified), and revealed, "I cannot move my leg." The resident complained of nausea and retching (unproductive effort to vomit); and was anxious due to the fall and laceration. The laceration was cleaned, locally (edges of the laceration) anesthetized (numbed), and eight sutures were placed. Medical record review of the Physician's Telephone Orders dated July 9, 2012, revealed the following orders: 1. X-ray of the right thigh, leg, and foot; 2. Clean incision (laceration) on right leg daily with normal saline; apply kerlix and xeroform dressing daily and PRN (as needed);	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445123	A. BUILDING ______ B. WING ______	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXIAN VILLAGE OF TENNESSEE	671 ALEXIAN WAY SIGNAL MOUNTAIN, TN 37377

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F 323	Continued From page 29	F 323		

3. Augmentin (antibiotic), 500 milligrams, by mouth, three times daily for five days.

Medical record review of the Medication Administration Record, dated July 1 through July 31, 2012, revealed the following:

1. The laceration was cleaned and dressed as ordered, for wound care;
2. Ativan, 0.5 milligrams, was administered by mouth, at 6:45 a.m., for anxiety;
3. Augmentin was started (at 8:00 a.m.), for prevention of infection;
4. Hydrocodone/Acetaminophen, 5 milligrams-325 milligrams, was administered by mouth, at 8:00 a.m., for pain.

Medical record review of the X-ray reports dated July 9, 2012, at 1:00 p.m., revealed two radiologic reviews (x-rays) of the right femur, right tibia and fibula, and the right foot, with the following impressions:

1. Femur, "...no gross (visible) acute displaced fractures..."
2. Tibia and fibula, "...no acute displaced fractures..."
3. Foot, "...no gross acute fractures of the foot...Prominent soft tissue swelling..."

Medical record review of a routine weekly hemoglobin lab report dated July 9, 2012, collected at 8:40 a.m., revealed a result of 6.4, (a 2.3 drop from the previous hemoglobin of 8.7 obtained on July 2, 2012).

Medical record review of a Physician's Telephone Order dated July 9, 2012, at 4:00 p.m., revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445123	A. BUILDING ______ B. WING ______	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXIAN VILLAGE OF TENNESSEE	671 ALEXIAN WAY SIGNAL MOUNTAIN, TN 37377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 30	F 323		

orders for a Stat (immediately) repeat of the hemoglobin and to call the Physician with the results.

Medical record review of a Nursing Progress Note dated July 9, 2012, at 11:15 p.m., revealed, "...Rcvd (received) call from (hospital) lab...critical value...(hemoglobin)...4.6...Observed res at that time non responsive, resp (respiration) was observable. Called family...to notify...this occurred at 8:10 p.m. Difficult to obtain vs (vital signs), b/p (blood pressure) 66/40, pulse 51. LM (left message) with answering service for MD (Medical Doctor). Re: (regarding)...hemoglobin. CNA called for the nurse 8:20 p.m., to observe 0 (no) resp. Supervisor called to room. Family arrived in facility approx (approximately) 9:50 p.m. & was made aware of res passing..."

Medical record review of a lab report dated July 9, 2012, revealed the repeat hemoglobin result was 4.6, which was a further drop of 1.8 from the previous hemoglobin of 6.4 obtained earlier at 8:40 a.m.

Medical record review of the Record of Death revealed the 66 year old resident's date and time of death were on July 9, 2012, at 8:25 p.m. The immediate cause of death revealed, "Sudden death due to questionable internal bleeding secondary to fall."

Review of facility in-service, ADL (Activities of Daily Living) Assistance and Kardex, dated November 23 through November 30, 2011, revealed, "...Explained the ADL coding...what each care level meant in the terms of type of assistance provided and the amount of staff

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ALEXIAN VILLAGE OF TENNESSEE	671 ALEXIAN WAY SIGNAL MOUNTAIN, TN 37377

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F 323	Continued From page 31 needed for the assistance...Explained the new kardex system. Instead of looking in the care plan book a Kardex notebook will be located at each nurse's station for each hall...The Kardex book will contain an information sheet on each resident to provide the level of assistance needed in ADL's...check this book prior to assisting any resident. This will begin December 1, (2011)..." Interview with CNA #1 on February 12, 2013, at 5:30 p.m., in the conference room, confirmed, "...I went into the resident's (#1) room to change (provide incontinence care)...(resident) just before the end of the shift. (Resident) was a big woman and I had to take both of my hands and push (resident) hard, with a lot of force, because resident was so big." As CNA #1 described "pushing" the resident, CNA #1 held both hands up, and with the palms of both hands facing forward, demonstrated a pushing gesture using both hands. "I didn't ask anybody to help me...I did it by myself (turned the resident)...When I pushed (resident) over, I couldn't see the opposite side of (resident) because (resident) was so big...when (resident) was turned, (resident) went over so hard and fast, I couldn't stop (resident)...As (resident) went over, (resident) hit (resident's) head on the night stand...there was a huge knot on her forehead (CNA #1 reached up and touched the right side of CNA #1's forehead)...I think the right side of (resident's) forehead...(resident) landed on the bottom (metal base of the table) of the over-the-bed table...there was blood on the floor from a gash on (resident's) right lower leg, and it was (resident's) bad leg...the one that hurt (resident) all the time. I should have had someone helping me. Before I went out to get	F 323		

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

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445123	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXIAN VILLAGE OF TENNESSEE	671 ALEXIAN WAY SIGNAL MOUNTAIN, TN 37377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 32 help, I made sure (resident) was breathing. (CNA #5) was in a nearby room...I hollered (called out loud) '(CNA #5)!'...because I knew (CNA #5) wasn't far from me...(CNA #5) came in and I stayed with (resident) while (CNA #5) went to get the nurse...(RN #1), Licensed Practical Nurse (LPN #3), (CNA #5), and myself were looking at (resident) trying to figure out how we were going to get (resident) off of the over-the-bed table...(RN #1), (CNA #5), and me pulled (resident) over as (LPN #3) pulled the over-the-bed table from under (resident)...We were talking to (resident)...(resident) was in pain...(LPN #3) got (resident) some Ativan to help (resident) calm down...(resident) said (resident) couldn't breathe...I guess it was an anxiety attack...(resident) calmed down with the Ativan. By this time the fire department was there...The fire department was looking for a lift to get (resident) back into the bed...They had to use a rug from downstairs, like a big mat you use to wipe your feet on. First they used a bed pad, rolling (resident) side-to-side until it (bed pad) was under (resident)...then went 1-2-3, and lifted (resident) up and over until they got (resident) onto the rug...Once on the rug, the fire department got (resident) onto the bed...(Physician) told me it was an accident that ended bad...I was responsible...I pushed (resident) over...I couldn't see that (resident) had lost (resident's) hand grip...I couldn't see (resident's) hand...(resident) was so big..." Continued interview revealed CNA #1 denied knowing the resident required the assistance of two for toileting and "Nobody in-serviced (educated) me or gave me any disciplinary action." Interview with Resident Assessment Information Coordinator (RAIC) #1 on February 13, 2013, at	F 323		

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

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445123	A. BUILDING ______ B. WING ______	C 02/21/2013

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F 323	Continued From page 33	F 323		

10:30 a.m., in the conference room, confirmed the resident was a total assist with turning, toileting, and transferring, and required the assistance of two or more staff. "The information was on the care plan and the kardex (a reference for resident-specific information related to nursing care); and the kardex is CNA-based. All CNA's were trained and required to use the kardex for resident specific information."

Interview with RN #1 on February 13, 2013, at 11:15 a.m., in the conference room, confirmed, "On the morning of July 9, 2012, I was called (RN #1 was on seventh floor; resident was on sixth floor), and told that (resident) was on the floor, and had fell from the bed. I assessed (resident's) neurological status...was alert, and oriented x3 (to person, place, time)...no neurological distress or changes. There was bloody fluid in the floor...was a cut on the (resident's) leg that was bleeding...right lateral calf (side area between knee and ankle)...The fire department was notified for assistance." RN #1 reviewed the Nursing Progress Notes and witness statement, written by RN #1, and confirmed the following injuries were observed by RN #1 from the resident's fall:

1. Left lateral torso-abrasion going into the axilla (armpit);
2. Abdomen-(belly)-abrasion;
3. Right hip and buttock area-abrasion and bruising;
4. Right lateral lower extremity (leg)-three-to-four lacerations;
5. Right thigh (upper leg), anterior (front)-large bruise;
6. Right elbow and forearm (part of arm between

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

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F 323	Continued From page 34 elbow and hand)-large bruise; 7. Right lateral calf-three-to-four inch laceration Continued interview with RN #1 confirmed RN #1 was aware the resident was a total assist and defined "total assist" as "required the assist of two or more staff." RN #1 confirmed to have observed only one CNA providing assistance to the resident, prior to the resident's fall. "I have seen one CNA assisting the resident...The CNA's knew not to provide ADL's with one CNA...but some did...It was not safe for the resident to be assisted by only one CNA..." Continued interview with RN #1 confirmed, "I did not report the CNA's non-compliance with the resident's required assistance to the Chief Nursing Officer (CNO), or Administrator...I didn't report it to anyone...I didn't do any disciplinary action or in-servicing was provided in response to the CNA's who were non-compliant with the resident's required assistance of two..." RN #1 confirmed the facility failed to ensure the resident received supervision and assistance to prevent the fall on July 9, 2012. Interview with the Physician on February 13, 2013, at 2:30 p.m., in the conference room, confirmed the Physician had completed a Fellowship in Geriatric Medicine, and had provided Physician services to the resident for over one and one-half years. "The resident was chronically anemic secondary to Chronic Kidney Disease, and was being treated with Aranesp, which required routine weekly monitoring of the resident's hemoglobin. The resident's hemoglobin historically ranged between 8.0-9.0; with one occasion of a false-low. On (July 9, 2012), the day of the fall, (resident) had a routine hemoglobin, which came back critically low, with	F 323		

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

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 35 a result of 6.4. Due to the previous false-low, I ordered a Stat repeat (of the hemoglobin). The repeat (blood specimen) was difficult for the nurses to obtain from the resident, but once successfully obtained, the result remained critically low...even lower at 4.6. I discussed (resident's) Advanced Directives with (resident). (Resident) refused to go to the hospital after the fall, and continued to refuse to go with the critically low hemoglobin results...This drop in the hemoglobin indicated internal bleeding...There is normally not a 'two-point drop' in an approximate ten-hour period; there would have to be a significant bleed for that much of a drop (in the hemoglobin)...With the resident's size, the bleed was not obvious..." Continued interview with the Physician confirmed, "...Due to the resident's obese and debilitated condition, it was not safe to turn or clean (resident) with one CNA; at least two were needed. While the resident was comorbidly obese...this accident (fall) was separate from (resident's) disease processes. The immediate cause of (resident's) death was due to the accident, not (resident's) diagnoses." Interview with CNA #4 on February 13, 2013, at 3:50 p.m., in the conference room, confirmed, "I routinely cared for (resident) and periodically, I reviewed the (resident's) care plan and kardex...I knew the resident was a total assist with two people, to turn and clean; but there were days I did it by myself, and there were days I got other CNA's to help with (resident)..." Interview with CNA #5 on February 13, 2013, at 3:50 p.m., in the conference room, confirmed, "...I knew (resident was a two-person assist...I knew it was not safe to do (resident) by myself but, I did.	F 323		

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

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

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F 323	Continued From page 36 If (resident's) bed needed changing, I always got another person to help because you would not be able to reach across the bed; it was too big and you would run yourself to death going from side-to-side. It was quicker if two did it (changed the bed). We had the kardex and care plan...I knew it took two people but I just thought I could get it done by myself and move on. Continued interview with CNA #5 confirmed, "On the morning of the fall (July 9, 2012), I was in a room beside of (resident's) room...I heard the loudest noise and I thought, 'God, I hope nobody fell out of bed.' About that time, (CNA #1) came rushing through the door (where CNA #5 was)...screaming, '(CNA #5)! (Resident) fell out of bed!' (Resident) was on the floor; (CNA #1) stayed with (resident) while I got help...I called upstairs and said, 'We need somebody down here now! We've got a resident in an incident and need somebody NOW!' (Resident) looked pitiful lying there. (RN #1) came down. EMS and the fire department responded to the call for help. The fire department had to help us get (resident) up...we got (resident) onto a bed pad and little-by-little, we were able to get (resident) onto a floor mat. Once on the mat, at least ten firemen, maybe more, lifted the resident to the bed. (Resident's) leg was messed up...cut...there was blood...we just had to get (resident) up...it was awful...it was pitiful." Interview with RN #2 on February 13, 2013, at 8:00 p.m., in the conference room, confirmed RN #2 routinely provided the care and services, and supervision of (resident). "(Resident) went 'down-hill' in 2011...had declined and required the assistance of two people. I was quite surprised...shocked...when I found out (resident)	F 323		

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

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 37 had fallen (on July 9, 2012), when only one CNA had attempted to assist (resident) with care. I didn't realize or even think it could be done, and obviously, it shouldn't have." Continued interview with RN #1 confirmed, "It was not safe for one to assist (resident) in turning, incontinence care...the potential for harm was so much greater." Interview by telephone with RN #3 on February 14, 2013, at 12:52 p.m., confirmed, "I was the previous CNO, at the time of (resident's) fall (on July 9, 2012). (Resident) was a two-person assist with turning and incontinence care and (resident's) assist level was on the kardex...'assist of two.' I recall this because it was a very serious event...we investigated it thoroughly..." Continued interview with RN #3 confirmed no one, to include (RN #1), had reported observing any CNA's who were non-compliant regarding using the required assistance with (resident). Interview by telephone with LPN #3 on February 14, 2013, at 6:42 p.m., confirmed LPN #3 provided assistance to the resident and nursing staff, after the resident's fall from the bed on July 9, 2012. (Resident's) leg was bleeding badly... (resident) was in a lot of pain and was anxious. (Resident) refused to go to the hospital...I gave (resident) anxiety and pain medication, and it helped...(resident) calmed down and slept. As the day went on, (resident) declined...it was a steady decline from the point of the fall until (resident) died. (Resident) was a two-person assist. This was all because the CNA (#1) failed to obtain the assistance of another person; and used the inappropriate turning technique, by turning (resident) in the opposite direction of the	F 323		

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

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445123	A. BUILDING ______ B. WING ______	C 02/21/2013

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F 323	Continued From page 38 CNA (#1) (instead of toward CNA #1)..." A second interview with CNA #1 on February 15, 2013, at 12:15 p.m., in the conference room, confirmed, "I was 'blurry' in my recall of the incident with assisting (resident) with incontinence care on July 9, 2012. I've had time to think about it, and my memory is now clear. I was trained in orientation to use the kardex to find the care and assist needs the residents' needed, including (resident). I was trained to always turn the resident toward me, never to turn away from me. I knew (resident) was needed the assist of two people...I just felt like I could do (resident) by myself. There was staff here to help me, and they would have if I had asked them; but I just didn't ask them. When I was changing (resident) (on July 9, 2012), (resident) was too big for me to pull (resident) to me. I had to push (resident) to get (resident) over and to be on the side where (resident's) bottom was to clean it. When I pushed (resident) over, I took my hands off of (resident) to get the brief ready; then I proceeded to clean (resident). It was at this point I noticed (resident) was going over (falling out of the bed). (Resident) was in an over-sized bed and it was impossible for me to get around the bed to break (resident's) fall. (Resident) was too big for me to see over (resident's) body and see that (resident's) hand was not on the side rail. Continued interview with CNA #1 confirmed, "I was never meaning to lie to you about this. It has been seven months and I had to re-think it. I was caught off-guard when I talked to you Tuesday night (February 12, 2013). I've had time to think about it and I wanted to clear this up." Interview with the CNO on February 15, 2013, at	F 323		

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

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445123	A. BUILDING ______ B. WING ______	C 02/21/2013

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F 323	Continued From page 39 2:00 p.m., in the conference room, confirmed the CNO began working for the facility in 1998, and has since held various positions, to include: MDS Coordinator, Quality Assurance Coordinator, Quality Assurance Director; and most current, CNO. "I personally trained (CNA #1) on using the kardex in November of 2011." Continued interview with the CNO confirmed, "I was the Quality Assurance Director at the time of the resident's fall (on July 9, 2012). I was aware of the fall and completed a root-cause analysis, which identified (CNA #1) failed to ensure the assist of two people when turning and providing incontinence care to the resident. (RN #1) was required to ensure any nursing staff who failed to provide the assistance required for (resident) was disciplined; and was required to ensure reporting of the non-compliance to administration (CNO especially), to ensure education and follow-up...this did not happen..." The CNO confirmed the facility failed to provide the required supervision and assistance to prevent (resident's) fall on July 9, 2012. Interview with the Administrator on February 20, 2013, at 2:00 p.m., in the conference room, confirmed had been made aware of the resident's fall at approximately 7:00 a.m., on July 9, 2012, (approximately one-hour after the fall). "Through investigation initiated (after) the fall, the facility confirmed, the resident was provided incontinence care by one CNA (#1), instead of two CNA's, as required for the safety of the resident. (RN #1) was the 'house supervisor' on July 9, 2012. (RN #1) was responsible for the general oversight of the nursing department on (RN #1's) shift. (RN #1) did not report (to the Administrator) any CNA's being non-compliant	F 323		

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

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 40 with providing the resident the required assistance to ensure the safety of the resident..." Continued interview confirmed CNA #1 failed to provide the correct turning technique and failed to provide the correct amount of assistance required for (resident) and the resident fell from the bed (on July 9, 2012) and RN #1 failed to ensure the required supervision to ensure the safety of (resident). The Administrator confirmed the facility failed to ensure (resident #1) received the required supervision and assistance to prevent the fall on July 9, 2012. In summary, CNA #1, failed to obtain the required assistance when turning and attempting to provide incontinence care to the resident, resulting in a fall with injury from the bed on July 9, 2012, at 6:00 a.m. RN #1 failed to ensure supervision and the required assistance for the resident's safety. The Immediate Jeopardy was effective from July 9, 2012, through February 20, 2013, and was removed on February 20, 2013. An Acceptable Allegation of Compliance, which removed the immediacy of the jeopardy, was received and corrective actions were validated by the surveyor through review of documents, staff interviews, and observations conducted onsite on February 21, 2013. The surveyor verified the corrective actions by: 1. Reviewing the facility's in-service records to ensure all nursing staff had been educated on neglect, assistance with ADL's, turning and positioning a resident, and non-compliance with assistance levels;	F 323		

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

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 41 2. Reviewing the facility's in-service records to ensure all nursing staff knew where the residents' care plans are and how to use them; 3. Reviewing the facility's in-service records to ensure all CNA staff had been educated on the electronic care plan system; 4. Reviewing the facility's in-service records to ensure all licensed nursing staff had been educated on and the implementation of the facility's policy and procedure on "Special Handling and Movement Challenges related to Bariatrics;" 5. Reviewing the corrective actions implemented for the non-compliant staff, (RN #1, CNA's #1, #4, and #5) 6. Conducting interviews with eight of nineteen licensed nursing staff employed to determine the level of comprehension gained through in-service education conducted regarding facility policies on neglect, assistance with ADL's, turning and positioning a resident, care plans, non-compliance with, (a) the supervision of resident care, and (b) assistance levels; 7. Conducting interviews with nineteen of forty-four CNA staff employed to determine the level of comprehension gained through in-service education conducted regarding facility policies on assistance with neglect, ADL's, turning and positioning a resident, care plans, and non-compliance with required assistance levels; 8. Conducting interviews and observations of seven CNA's regarding the use of the electronic	F 323		

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

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 42 care plan system; 9. Observing the level of assistance CNA's provided to five residents requiring the assistance of two, in accordance with the resident's care plan and electronic care plan system; Non-compliance continues at a "D" level for monitoring corrective actions. Refer to F-282 (J). C/O #30155	F 323	F 520, §483.75(o)(1), QAA COMMITTEE COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS Resident #1 expired July 9, 2012. The facility conducted a Root Cause Analysis on July 12, 2012. Recommended actions were reviewed and implemented on July 17, 2012. The facility has ensured that the QAA Committee meets at least quarterly to identify issues with respect to which quality assessment and performance improvement activities are necessary; and monitors to ensure that such quality assessments and assurance activities take place. Residents requiring the assistance of two persons for bed mobility have been, and will continue to be, identified through nursing assessments and through the examination of MDSs and Care Plans. Identified residents have been, and will continue to be, entered into the Electronic Activities of Daily Living (EADL)/Kardex/Care Plan systems to cue staff to resident needs. Director of Nursing or designee(s) have provided education for the nursing staff related to recognition of residents requiring the assistance of two persons for bed mobility, compliance with the resident's care plans, proper techniques for turning and positioning the residents, and the required reporting of any noncompliance. The nursing staff was educated by July 19, 2012 concerning the proper assessment of residents for required assistance with turning and the entry of accurate and consistent information in the Kardex/Care Plan/MDS systems (documentation of staff attendance was incomplete; therefore, repeat in-service training was conducted and fully documented on February 20, 2013). Care Tracker resident profiles were updated on July 23, 2012 to include the number of staff required to assist with bed mobility. Director of Nursing or designee(s) have provided education for the nursing staff (continued next page)	
F 520 SS=J	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify	F 520		

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

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FORM APPROVED
OMB NO. 0938-0391

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 43 and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility investigations, review of facility policy, and interview, the facility failed to ensure the Quality Assurance (QA) Committee implemented a plan to train and educate on the required supervision and safe assistance to prevent a fall for one resident (#1) of eight residents reviewed. The facility's failure to ensure resident #1 was provided the required supervision and safe assistance when turning the bedridden resident resulted in a fall from the bed with multiple bodily injuries and sudden death on July 9, 2012. The facility's failure placed resident #1 in Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment or death). The Administrator and Chief Nursing Officer were informed of the Immediate Jeopardy in the Conference Room on February 20, 2013, at 1:35 p.m. Substandard Quality of Care was cited under tag F-323 at a scope and severity level of a "J." The findings included: Review of a Root Cause Analysis (no date) revealed, "...What steps...contributed to...the event? Associate usually performed this duty	F 520	related to recognition of residents requiring the assistance of two persons for bed mobility, compliance with the resident care plan, proper techniques for turning and positioning the residents, and the required reporting of any noncompliance. The facility staff member involved with Resident #1's care was promptly counseled regarding required compliance with the Kardex/Care Plan/MDS systems and the proper turning/transfer technique. This staff member was subsequently suspended. RN#1 was counseled regarding the need to immediately report and correct staff non-compliance with resident's plan of care and subsequently was suspended and required to take an online course regarding supervisory skills. The Director of Nursing or designee(s) will conduct weekly checks for 30 days to ensure accuracy and consistency of the Kardex/Care Plan/MDS entries, the CNAs' documentation in the EADL, and will visually observe and interview nursing staff to monitor compliance. The Director of Nursing or designee(s) will report findings to the QAA Committee and the CEO of the facility. Based on these findings, the QAA Committee, together with the CEO, will determine whether any additional corrective actions and additional monitoring is required, and will assure implementation of the same. The CEO will report on compliance with the Plan of Correction to the Board of Directors (the "Quality Council"), which has oversight responsibilities for quality resident services and for assurance of compliance with regulations and standards of governmental organizations.	03/08/13

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445123	A. BUILDING ______ B. WING ______	C 02/21/2013

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F 520	Continued From page 44 alone...What human factors were relevant to the outcome? One CNA (Certified Nursing Assistant) assisting the resident during rounds. Resident stated that '(CNA #1) moves me kind of fast'...Are there any other factors that have directly influenced this outcome? Resident's wt (weight) was 430# (pounds)..." Continued review revealed a plan for in-services to be completed for Resident assistance requirements for turning and incontinence care and "...educated in the correct lifting/turning procedures..." Review of facility in-service documentation and personnel records revealed the facility failed to provide the planned education and in-service training for using two CNA's to provide repositioning and incontinence care and lifiting/turning procedures. Interview with the CNO on February 15, 2013, at 2:00 p.m., in the conference room, confirmed the CNO began working for the facility in 1998, and has since held various positions, to include: MDS Coordinator, Quality Assurance Director; and most current, CNO. "I personally trained (CNA #1) on using the kardex in November of 2011." Continued interview with the CNO confirmed, "I was the Quality Assurance Director at the time of the resident's fall (on July 9, 2012). I was aware of the fall and completed a root-cause analysis, which identified (CNA #1) failed to ensure the assist of two people when turning and providing incontinence care to the resident. (RN #1) was required to ensure any nursing staff who failed to provide the assistance required for (resident) was disciplined; and was required to ensure reporting of the non-compliance to administration (CNO especially), to ensure education and	F 520		

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F 520	Continued From page 45 follow-up...this did not happen..." The CNO confirmed the facility failed to provide the required supervision and assistance to prevent (resident's) fall on July 9, 2012, and failed to provide the inservices as developed and planned after completion of the Root Cause Analysis. Refer to F-282 (J); and F-323 (J) Substandard Quality If Care. C/O #30155	F 520		