

45th day

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION <i>acceptable</i>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/25/2012
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NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT MARYVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2848 SEVIERVILLE RD MARYVILLE, TN 37804
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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 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, review of facility investigation</p>	F 157	<p>F 157 – Resident #10 Physician was notified of the May 24, 2012 incident at 10:45am on May 24, 2012. The Medical Director was notified of the Incident later in the day by the Director of Nursing.</p> <p>The Physician Notification policy has been reviewed and updated.</p> <p>All nursing staff have been re-educated by the DON or designee on the Physician Notification policy and proper documentation of Physician notification.</p> <p>The DON or designee will audit the Medical Records of 5 residents per week for 4 weeks, then 5 residents per month for 3 months for appropriate Physician Notification documentation.</p>	7/13/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Rosa L. Brown* TITLE *Administrator* (X6) DATE *7/13/12*

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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NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT MARYVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 2648 SEVIERVILLE RD MARYVILLE, TN 37804		
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F 157	<p>Continued From page 1</p> <p>documentation, and interview, the facility failed to notify the physician in a timely manner of an allegation of sexual abuse for one resident (#10) of eleven sampled residents.</p> <p>The findings included:</p> <p>Review of facility policy RS-NSG -022 most recently revised January 5, 2005, revealed, "... Topic: Physician Notification...It is the policy of (facility), that the physician will be notified about any change in resident condition according to Federal and State guidelines...if the physician does not respond to the phone call after two attempts (30 minutes apart), the Medical Director will be contacted. Messages will not be left on the physician's answering machine...when a prompt response is indicated..."</p> <p>Medical record review of a Skilled Daily Nurses Note authored by Licensed Practical Nurse (LPN) #2 dated May 24, 2012, at 5:00 a.m., revealed, "CNA's (Certified Nursing Assistants) informed this nurse resident was upset and stating (resident) had been raped...This nurse called resident's daughter...Also message left for social worker." Continued review revealed no documentation regarding physician notification.</p> <p>Medical record review of a nurse's note (LPN #2) dated May 24, 2012, at 6:30 a.m., revealed no documentation regarding physician notification.</p> <p>Medical record review of a nurse's note (LPN #3) dated May 24, 2012, at 10:45 a.m., revealed, "Rec'd (received) new order to send to (hospital)..."</p> <p>Medical record review of a nurse's (Director of Nursing) note dated June 4, 2012, revealed, "Late</p>	F 157	The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate.		

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F 157	<p>Continued From page 2</p> <p>entry for 5/24/12: Received call from RN (registered nurse) supervisor at 5:15 (a.m.)...resident stated (resident) had been raped...Daughter declined sending to ER...(6:15 a.m.)...daughter in room...Staff reported (resident's physician) was not the on-call MD (medical doctor) and daughter agreed to wait until (resident's physician's) office opened at (8:00 a.m.)...10:30 (a.m.) Advised (resident's physician) returned phone call and wanted the resident sent to the ER (emergency room) for evaluation...(1:30 p.m.) Medical Director advised of allegation..."</p> <p>Review of facility investigation documentation dated May 24, 2012, revealed, "...Time of incident/accident 5:00 a.m...Name of physician notified (space was blank) Time of notification (space was blank)..."</p> <p>Telephone interview with LPN #2 on June 14, 2012, at 11:20 p.m., revealed the resident's physician was not on call, the resident's daughter preferred the resident's physician be notified of the allegation, and LPN did not notify a physician of the allegation.</p> <p>Interview with LPN #3 on June 25, 2012, at 9:50 a.m., in a conference room, revealed LPN #3 left a message on the resident's physician's answering machine on May 24, 2012, at approximately 8:30 a.m. and did not make another attempt to notify the physician. Continued interview revealed the physician called and LPN #3 received an order to send the resident to a hospital at 10:45 a.m. Continued interview confirmed physician notification was delayed and the facility failed to implement the Physician Notification policy for Resident #10 on May 24,</p>	F 157		
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F 157	Continued From page 3 2012.	F 157		
F 225 SS=D	<p>483.13(c)(1)(II)-(III), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F 225	<p>F - 225 - The UIRS report dated June 6, 2012 has been closed by the State of Tennessee; therefore a corrected report will not be submitted in order to correct the miss-keyed entry of incident date.</p> <p>The Abuse policy has been reviewed for any needed updates. Policy was believed to be in compliance with Federal and State regulations.</p> <p>The Administrator has re-educated all Department Heads on the Abuse policy and correct investigation protocols.</p> <p>The Director of Nursing has re-educated all nursing staff on the Abuse policy and correct investigation protocols.</p> <p>All allegations of abuse will be thoroughly investigated according to the policy.</p>	7/13/12

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F 225	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, review of facility investigation documentation, observation, and interview, the facility failed to thoroughly investigate and timely report an allegation of abuse for one resident (#10) of eleven sampled residents.</p> <p>The findings included:</p> <p>Review of facility policy number RS-NSG-041 most recently revised April 3, 2005, revealed, "...Topic: Abuse/Neglect/Mistreatment...When a person witnesses or suspects abuse...the person must report it immediately to the DON (Director of Nursing) and Administrator...will thoroughly investigate and promptly report to proper authorities all allegations or incidents of resident abuse...will notify the Administrator of the facility immediately that an incident has been alleged or occurred and other officials in accordance with State law including the state survey and recertification agency...within 5 working days of the incident..."</p> <p>Medical record review revealed Resident #10 was admitted to the facility on May 11, 2012, with diagnoses including Dementia with Behavior Disturbance.</p> <p>Medical record review of a Skilled Daily Nurses Note dated May 24, 2012, at 5:00 a.m., revealed,</p>	F 225	<p>Any allegations will be reviewed and audited by the Administrator. All submitted UIRS reports will be audited by the Administrator and the VP of Operations for compliance with reporting protocols. Audits will be effective for any reported incidents over the next 6 months.</p> <p>The results of any audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting and recommendations made as appropriate.</p>	
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F 225	<p>Continued From page 5</p> <p>"CNA's (Certified Nursing Assistants) informed this nurse resident was upset and stating (resident) had been raped..." Medical record review of a physician's order dated May 24, 2012, at 10:45 a.m., revealed, "Send to (hospital) for eval et tx as Ind (evaluation and treatment as indicated)."</p> <p>Medical record review of a hospital History and Physical dated May 24, 2012, revealed, "...Here for examination of alleged sexual assault..."</p> <p>Medical record review of hospital nurses' notes dated May 24, 2012, revealed, "... (11:48 a.m.) arrived from (facility). Complaints (complains) of sexual assault this a.m., in (resident's) room, at facility... 12:01 p.m.)... police here to see patient... (1:00 p.m.) Pt (patient) in with same (Sexual Assault Nurse Examiner) nurse..." Medical record review of a hospital nurse's note dated May 24, 2012, at 3:10 p.m., revealed, "...discharged to home (facility)..."</p> <p>Review of facility investigation documentation dated May 24, 2012, revealed, "...Report... Resident stated... was raped and couldn't get out of bed because he would kill (resident)..."</p> <p>Review of facility investigation documentation (a single handwritten statement signed by two CNAs) (#3 and #4) dated May 24, 2012, revealed, "... (resident) stated "I can't get up that man said he would kill me because he raped me... I tried to explain... that there wasn't any men in... room... I went and told (House Supervisor)..." Continued review revealed no documentation regarding the identity of the CNA responsible for notification of</p>	F 225		

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F 225	<p>Continued From page 6 the House Supervisor.</p> <p>Review of facility investigation documentation (a single statement signed by two Licensed Practical Nurses (LPN) (#1 and #2), dated May 24, 2012, revealed, "CNA reported resident states, '...has been raped and if (resident) gets out of bed he is in (resident's) room and will kill (resident)' this nurse and another nurse working the floor entered the room...supervisor notified message left for Social Worker and call to D.O.N. (Director of Nursing). Roommate and floor staff also questioned, no male has been seen entering room this shift..." Continued review revealed no documentation regarding the identity of the LPN responsible for notification of the supervisor, Social Worker, or the DON. Continued review revealed no documentation regarding the identify of staff responsible for questioning staff and/or statement of the resident's roommate.</p> <p>Review of facility investigation documentation (House Supervisor's statement) dated May 24, 2012, revealed, "CNA's (CNAs) reported to nurse on the floor...resident...made the statement that a man had raped (resident) when they were in...changing (resident)...The 2 LPN's on the floor...examined the resident...then came back to the desk and called (resident's) daughter...daughter changed her (resident) again...mother kept saying it's on me. Don't know what (resident) was referring to...Social Worker notified of alleged in incident..." Continued review revealed no documentation regarding the identify of the CNAs or two LPNs working the floor or the LPN responsible for notification of the resident's daughter.</p>	F 225		

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F 225	<p>Continued From page 7</p> <p>Review of facility investigation documentation dated June 4, 2012, revealed, "Late Entry for 5/24/12: Received call from RN (Registered Nurse) supervisor at 5:15 (a.m.)...(6:15 a.m.) I spoke with RN supervisor and reviewed statements of staff. Sitter on floor asked for name and contact information..." Continued review revealed no documentation regarding a statement from the sitter.</p> <p>Review of facility reporting documentation dated June 6, 2012, revealed, "...Date of Occurrence: 05/28/2012...staff interviewed the resident, the resident's daughter, the roommate...After completing internal investigation we have found this allegation of abuse to be unsubstantiated..."</p> <p>Observation on June 13, 2012, at 9:20 a.m., revealed the resident seated in a chair and the resident's son-in-law at the bedside. Continued observation and interview revealed the resident was alert, disoriented, and without complaint of mistreatment.</p> <p>Telephone interview with Police Detective #1 on June 1, 2012, at 2:03 p.m., revealed the facility did not report the allegation to local law enforcement.</p> <p>Interview with the Director of Nursing on June 13, 2012, at 12:34 p.m., in a conference room, revealed a thorough investigation included individual statements from staff, and confirmed the facility failed to complete a thorough investigation of Resident #10's allegation of sexual abuse.</p> <p>Telephone interview with an Adult Protective</p>	F 225		
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ASBURY PLACE AT MARYVILLE

STREET ADDRESS, CITY, STATE, ZIP CODE

2648 SEVIERVILLE RD
MARYVILLE, TN 37804

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F 225	Continued From page 8 Services caseworker on June 25, 2012, at 9:30 a.m., revealed the facility did not report the allegation to Adult Protective Services. Telephone interview with the Administrator on June 25, 2012, at 10:20 a.m., confirmed the facility failed to accurately and/or timely report Resident #10's allegation of sexual abuse.	F 225		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide assistance with hygiene for one resident (#3) of eleven sampled residents. The findings included: Resident #3 was admitted to the facility on January 17, 2012, with diagnoses including Morbid Obesity, Chronic Kidney Disease, and Diabetes Mellitus. Medical record review of a Minimum Data Set dated April 24, 2012, revealed the resident had no cognitive impairment or mood or behavioral problems. Continued review revealed the resident was frequently incontinent of bowel and bladder and totally dependent on staff for toileting and	F 312	F - 312 - Resident # 3 brief was changed and ADLs completed on June 12, 2012 when surveyor told Administrator of incident. All staff on second floor was inserviced on June 12, 2012 of expectations for prompt response to call lights on second floor. The DON or designee has re-educated all nursing staff on the Call light policy. All nursing staff have been instructed to answer call lights promptly. If unable to understand the resident's request, the nursing staff should go to the resident's room to address the request.	7/13/12

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F 312	<p>Continued From page 9 hygiene.</p> <p>Medical record review of a care plan effective through July 26, 2012, revealed, "...keep clean and dry...wing brief..."</p> <p>Observation on June 12, 2012, at 9:20 a.m., revealed the resident in bed and the resident's left leg was amputated below the knee.</p> <p>Interview with the alert, oriented resident on June 12, 2012, at 9:20 a.m., revealed a concern about the staff's response time to call lights and the resident's brief had been changed after breakfast. The resident stated, "They don't come prompt, I'll tell you. Sometimes I lay wet."</p> <p>Observation on June 12, 2012, at 9:24 a.m., revealed the resident's call light was activated and staff inquired (via the call system), "Can I help you?" Continued observation revealed the resident stated, "I need changed. I'm wet." Continued observation revealed staff did not verbally acknowledge the resident's request.</p> <p>Observation on June 12, 2012, at 9:40 a.m., revealed four staff stood in the corridor at the nurse's station.</p> <p>Interview with Certified Nursing Assistant (CNA) #2 on June 12, 2012, at 9:50 a.m., in the second floor corridor, revealed the facility had no method for monitoring residents' requests for assistance and/or response to requests.</p> <p>Observation on June 12, 2012, from 9:24 a.m. through 9:55 a.m., revealed staff did not respond to the resident's request for assistance.</p>	F 312	<p>The DON or designee will conduct random audits of call light responses for timeliness and acknowledgement of resident's requests. Audits will be done on 10 residents per week for 4 weeks, then 10 residents per month for 3 months.</p> <p>The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate.</p>	
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F 312	Continued From page 10	F 312		
F 323 SS=G	<p>Interview with the Administrator on June 12, 2012, at 9:55 a.m., at the nurse's station, confirmed the facility failed to provide the requested assistance with activities of daily living for Resident #5 on June 12, 2012.</p> <p>C/O: #29690 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility investigation documentation, observation, and interview, the facility failed to ensure safety devices were in place to prevent falls with injury for one (#5) of eleven residents reviewed, resulting in harm to Resident #5 who was transferred to the Emergency Department for sutures for a head laceration.</p> <p>The findings included: Resident #5 was admitted to the facility on October 7, 2010, with diagnoses including Vascular Dementia with Depression, Anxiety, and Abnormality of Gait.</p>	F 323	<p>F - 323 -Resident # 5 was screened by Therapy on May 2, 2012. Side rails have been raised x 2 with mats on floor beside bed. Care plan has been updated with current safety precautions.</p> <p>Side rail assessments have been completed for all residents on second floor south.</p> <p>The DON or designee has re-educated the nursing staff on placement of side rails and other safety devices as indicated on the resident's plan of care.</p> <p>The DON or designee will conduct random audits of resident care plans and visualize the resident for proper safety precautions. Audits will be done on 10 residents per week for 4 weeks, then 10 residents per month for 3 months.</p>	7/13/12

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

FORM APPROVED
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/25/2012
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NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT MARYVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2648 SEVIERVILLE RD MARYVILLE, TN 37804
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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 323	<p>Continued From page 11</p> <p>Medical record review of a Psychiatric Note dated March 15, 2012, revealed, "...confused...Orientation: self...Insight:poor...Judgment: poor..."</p> <p>Medical record review of the Minimum Data Set dated March 20, 2012, revealed the resident was severely impaired with decision-making skills, non-ambulatory, totally dependent on staff for all activities of daily living, and required the assistance of two staff for transfers.</p> <p>Medical record review of a Fall Risk Assessment dated March 21, 2012, revealed a score of seven and included, "...Requires aid with transfers...and is unwilling/unable to ask for assistance...If resident score 4 or more a fall leaf will be placed outside the door and care planned at risk."</p> <p>Medical record review of the care plan effective through June 21, 2012, revealed, "...at risk for falls related to history of fall...safety unawareness...Full side rails with padding to bed..."</p> <p>Medical record review of a nurse's note dated April 30, 2012, at 8:50 p.m., revealed, "Heard alarm sounding, upon entering room resident noted lying on floor beside bed. Laceration freely bleeding noted to R (right) forehead. Pressure applied to stop bleeding. R siderail down ...Sent to (Hospital #1)..."</p> <p>Medical record review of a physician's order dated April 30, 2012, revealed, "may go to (hospital) for eval & tx (evaluation and treatment)."</p>	F 323	<p>The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate.</p>	

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/25/2012
NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT MARYVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 2648 SEVIERVILLE RD MARYVILLE, TN 37804		
(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	<p>Continued From page 12</p> <p>Medical record review of a nurse's note dated April 30, 2012, at 8:50 p.m., revealed, "...Sent to (hospital)..."</p> <p>Medical record review of a hospital Emergency Room record dated April 30, 2012, revealed, "...Chief Complaint: Fall ...presents via EMS (Emergency Medical Services) from nursing home secondary to sustaining a head laceration. Apparently the patient was placed in bed and bed rails were not put in place and the patient slid out of bed striking the floor ...laceration noted on the forehead ...pertinent history ...Left side weakness Dementia ...Insomnia ...total of ten ...sutures were placed ...Diagnosis: 10 Cm (centimeter) Facial Laceration ...is discharged to nursing home ..."</p> <p>Review of facility investigation documentation dated April 30, 2012, revealed, "...Describe exactly what happened...Resident found lying on floor next to bed. Alarm was sounding. Laceration to forehead. Pressure applied to stem bleeding. Side rail x 1 down...Nursing applied pressure to head wound. Paramedic applied head bandage..." Continued review revealed, "...What was the resident doing prior to the fall? Placed into Bed for HS (bedtime)...Resident activity prior to fall: in bed...Medication: Ativan 0.5 mg (milligrams) @ 8 PM...aware of own limitations: no...Environmental factors...Side rails: up x 1..."</p> <p>Medical record review of a nurse's note dated May 1, 2012, at 12:15 a.m., revealed, "Resident returned to facility ...DRSGS (dressings) applied to forehead, forearm, and bil (bilateral) elbows ..."</p> <p>Medical record review of a Therapy Screen dated</p>	F 323			

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/25/2012
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NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT MARYVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2648 SEVIERVILLE RD MARYVILLE, TN 37804
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F 323	<p>Continued From page 13</p> <p>May 2, 2012, revealed, "...Diagnosis/Condition/Problem: Fell 4/30/12 OOB (out of bed). siderail down on bed...Comments: Pt (patient) has been in bed or Jeri-chair (geri-chair) @ all times. Lift use to get pt OOB..."</p> <p>Observation on June 12, 2012, at 9:30 a.m., revealed the resident asleep in bed, siderails raised, and mats on both sides of the bed.</p> <p>Observation on June 13, 2012, at 9:58 a.m. revealed the resident awake, in bed, and a Certified Nursing Assistant (CNA) #1 shaved the resident. Continued observation and interview with the resident revealed siderails raised, mats on the floor on both sides of the bed; the resident was unable to respond appropriately to questions and unaware of (resident's) fall.</p> <p>Interview with CNA #1 on June 13, 2012, at 9:58 a.m., in the resident's room, revealed the resident did not attempt to get out of bed, and the CNA stated, "(Resident) does scoot around..."</p> <p>Interview with the Director of Nursing (DON) on June 13, 2012, at 3:00 p.m., in a conference room, confirmed the facility failed to ensure siderails were in place to prevent a fall with injury for Resident #5 on April 30, 2012.</p>	F 323		
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