

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

POC (FAX)  
Recite #2

P.005/017  
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  R-C 08/08/2012
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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 000	<p><b>INITIAL COMMENTS</b></p> <p>On August 8, 2012 the first follow-up survey for a no-opportunity to correct deficiency (F-323 G) cited on a complaint survey of June 25, 2012 was completed.</p> <p>On the August 8, 2012 follow-up survey F-323 was found not corrected as per the facility's Plan of Correction alleging a compliance date of July 13, 2012. F-323 was recited at a scope and severity of a D. All other deficiencies cited on the June 25, 2012 survey were corrected on the first follow-up survey of August 8, 2012.</p> <p>New deficiencies cited on the first follow-up survey of August 8, 2012 were F-272 D, F-281 D, and F-319 D.</p>	F 000		
F 272 SS-D	<p><b>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</b></p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:                  Identification and demographic information;                  Customary routine;                  Cognitive patterns;                  Communication;                  Vision;                  Mood and behavior patterns;                  Psychosocial well-being;                  Physical functioning and structural problems;</p>	F 272	<p>F 272 – Side rail assessment for Resident #4 was completed by the ADON on 8/10/12.                  Side rail assessment for Resident #5 was completed by the ADON on 8/10/12.</p> <p>Side rail assessments were completed by the ADON for all residents on 2 South between 8/10/12 and 8/24/10. All 2 South assessments have been verified to have completion dates on or after June 25, 2012.</p>	8/24/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 272	<p>Continued From page 1</p> <p>Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to assess the use of siderails for one resident (#4) and reassess the use of siderails for one resident (#5) of six sampled residents.</p> <p>The findings included:</p> <p>Review of the facility's Plan of Correction with a correction date of July 13, 2012, revealed, "...Side rails have been raised x (times) 2 with mats on floor beside bed. Care plan has been updated with current safety precautions. Side rail assessments have been completed on all residents on (resident's floor)..."</p>	F 272	<p>All other resident side rail assessments will be completed by 8/24/12.</p> <p>The RN staff education coordinator has re-educated the nursing staff on placement of side rails and other safety devices as indicated on the resident's plan of care. This education occurred between 8/23/12 and 8/28/12 for all working nursing staff.</p> <p>The DON, ADON or RN will conduct random audits of resident care plans and visualize the resident for proper safety precautions beginning 8/22/12. Audits will be done on 10 residents per week for 4 weeks, then 10 residents per month for 3 months.</p>		

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F 272	<p>Continued From page 2</p> <p>Resident #5 (#5 for survey completed June 25, 2012) was admitted to the facility on October 7, 2010, with diagnoses including Vascular Dementia with Depression.</p> <p>Medical record review of a Side Rail Evaluation dated May 15, 2012, revealed the resident was unable to get out of bed safely and included, "...Interventions utilized...will communicate with family about removing full rails and replace with half rails..." Medical record review revealed no documentation regarding another Side Rail Evaluation.</p> <p>Medical record review of a Minimum Data Set dated June 19, 2012, revealed the resident was impaired with decision-making skills, totally dependent on staff for all activities of daily living, and had a history of falls.</p> <p>Medical record review of a care plan dated June 20, 2012, revealed, "...SAFETY PRECAUTIONS...Floor mats...at risk for falls...safety unawareness...Full side rails with padding to bed..."</p> <p>Medical record review of a physician's order dated April 30, 2012, revealed, "Mats at bedside for protection."</p> <p>Observation on August 8, 2012, at 9:18 a.m., revealed the resident asleep on a low bed, a 3/4 unpadded siderail on the right side of the bed was raised and the siderail on the left side of the bed was lowered. Continued observation revealed a mat on the floor on the left side of the bed and no mat on the right side of the bed.</p>	F 272	<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 starting in September, monthly for three (3) months and changes will be made based on recommendations, as appropriate.</p>	

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F 272	<p>Continued From page 3</p> <p>Observation with Licensed Practical Nurse (LPN) #1 on August 8, 2012, at 9:20 a.m., revealed the resident on the bed and the left siderail on the resident's bed was not raised.</p> <p>Observation on August 8, 2012, at 10:23 a.m., revealed the resident on the bed and the left side rail was not raised.</p> <p>Interview with Certified Nursing Assistant (CNA) #1 on August 8, 2012, at 10:30 a.m., in the hallway outside the resident's room, revealed CNA #1 left the siderail down after providing care for the resident. Continued interview revealed the information regarding safety devices required by residents was available in a notebook, and CNA #1 stated, "...It (left siderail) stays down."</p> <p>Review of a list in a notebook "Restraints Bedrails" with CNA #1 on August 8, 2012, at approximately 10:35 a.m., in a nurse's station, revealed, "... (Resident #5) Bed lowest position - Bedrails Down x 2-Leftside Bedside mat x 1 (Half Rails)..."</p> <p>Interview with LPN #2 (the resident's nurse) on August 8, 2012, at 10:50 a.m., at a nurse's station, revealed safety precautions to prevent falls for Resident #5 included a low bed with the left siderail lowered.</p> <p>Interview with Nurse Practitioner (NP) #1 on August 8, 2012, at 11:07 a.m., revealed the facility attempted to reduce the number of residents requiring the use of siderails. NP #1 stated, "...feel like (Resident #5) would benefit from (the use of) two siderails..."</p>	F 272			

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F 272	<p>Continued From page 4</p> <p>Interview with the Director of Nursing on August 8, 2012, at 9:30 a.m., in the family room, revealed no assessment for use of siderails had been completed since May 15, 2012. Continued interview confirmed the facility failed to ensure safety devices were in place to prevent falls for Resident #5 and/or implement the plan of correction.</p> <p>Resident #4 was admitted to the facility on May 11, 2012, with diagnoses including Dementia with Behavior Disturbance.</p> <p>Medical record review of a care plan dated May 11, 2012, revealed no documentation regarding the use of siderails.</p> <p>Medical record review of a nurse's note dated August 3, 2012, at 7:00 a.m., revealed, "...found this morning by nurse hanging on to side rail with body hanging of (off) side of bed..."</p> <p>Medical record review revealed no documentation regarding assessment for use of siderails.</p> <p>Interview with the Assistant Director of Nursing (ADON) on August 8, 2012, at approximately 3:00 p.m., at the second floor nurse's station, confirmed the facility failed to complete a siderail assessment for Resident #4.</p>	F 272			
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 281	F - 281 - Side rails were padded and mats were placed at bedside per Physician order for Resident #5 by the LPN on 8/8/12.	8/24/12	

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F 281	<p>Continued From page 5 by: Based on medical record review, observation, and interview, the facility failed to follow physician's orders for one resident (#5) of six sampled residents.</p> <p>The findings included:</p> <p>Resident #5 was admitted to the facility on October 7, 2010, with diagnoses including Vascular Dementia with Depression.</p> <p>Medical record review of a recapitulation (short summary) of physician's orders effective through August 31, 2012, revealed, "...padded siderall...to decrease risk of injury...Mats at bedside for protection..."</p> <p>Observation on August 8, 2012, at 9:18 a.m., revealed the resident asleep on a low bed, the right siderall was raised and unpadded, a mat on the floor on the left side of the bed, and no mat on the right side of the bed.</p> <p>Observation with Licensed Practical Nurse (LPN) #1 on August 8, 2012, at 9:20 a.m., revealed the right siderall was raised and unpadded and no mat on the floor on the right side of the bed.</p> <p>Observation on August 8, 2012, at 10:23 a.m., revealed the resident on a low bed, the right siderall was raised and unpadded, a mat on the floor on the left side of the bed, and no mat on the right side of the bed.</p> <p>Interview with Registered Nurse (RN) #1 on August 8, 2012, at 9:55 a.m., in the family room, confirmed the facility failed to follow the</p>	F 281	<p>Verification completed on 8/22/12 by the DON that all Physician orders related to safety devices have been reflected on the Care Plans for all residents on 2 South.</p> <p>The Director of Nursing, along with the RN education coordinator has re-educated all nursing staff on the proper verification of Physician orders to the Resident Care Plan. This education was implemented on 8/23/12 and continued through 8/28/12 with all working nursing staff.</p> <p>The DON, ADON, or RN will conduct random audits of resident care plans beginning 8/22/12 to ensure that appropriate Physician orders have been updated. Audits will be done on 10 residents per week for 4 weeks, then 10 residents per month for 3 months.</p>	

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<p>F 281</p> <p>F 319 SS-D</p>	<p>Continued From page 6 physician's orders for Resident #5. 483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to follow a physician's order for a mental health evaluation for one resident (#4) of six sampled residents.</p> <p>The findings included:</p> <p>Resident #4 was admitted to the facility on May 11, 2012, with diagnoses including Dementia with Behavior Disturbance.</p> <p>Medical record review of a nurse's note dated July 21, 2012, at 2:00 p.m., revealed, "...has been roaming the floor all shift, refuses to be laid down...attempts to leave floor...all attempts @ (at) intervention...have failed..." Medical record review of a nurse's note dated July 26, 2012, at 6:00 p.m., revealed, "...spit out part of meds (medications)..." Medical record review of a nurse's note dated July 28, 2012, at 6:00 p.m., revealed, "...found on ground floor and was wandering on ground floor looking for a way out."</p> <p>Medical record review of a nurse's note dated July 27, 2012, at 10:00 a.m., revealed, "N/O (new</p>	<p>F 281</p> <p>F 319</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 starting in September, monthly for three (3) months and changes will be made based on recommendations, as appropriate.</p> <p>F - 319 - Resident #4 had a Psychiatric Evaluation completed on July 27, 2012 after the Physician order was received.</p> <p>Evaluation had not been placed on the chart, so Surveyor did not see report.</p> <p>Evaluation recommendations were sent to the physician by the LPN and new orders were received on 8/9/12.</p>	<p>8/24/12</p>
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F 319	<p>Continued From page 7 order) received for psych (psychiatric)..."</p> <p>Medical record review of a physician's order dated July 27, 2012, revealed, "Psych eval &amp; treat (evaluation and treatment)." Medical record review revealed no documentation regarding a psychiatric evaluation.</p> <p>Observation on August 8, 2012, at 12:00 p.m., revealed the resident seated in a wheelchair with the arms crossed across the chest. Observation on August 8, 2012, at 3:50 p.m., revealed the resident seated in a wheelchair near the nurse's station on the secure unit (locked unit) and two nurses attended the resident.</p> <p>Interview with Licensed Practical Nurse (LPN) #3 on August 8, 2012, at approximately 3:52 p.m., at the nurse's station, revealed the resident's behavior during the afternoon of August 8, 2012, had required intervention by the staff. LPN #3 stated, "... (Resident) has been swinging at everybody the last several hours. It comes and goes..." Continued interview revealed a nurse usually faxed an order for a psych evaluation to the mental health provider and LPN #3 was unable to locate documentation regarding a psych evaluation for Resident #4. Continued interview revealed LPN #3 had spoken with the Psych Nurse Practitioner (PNP) (regarding another resident) on August 1, 2012, and the PNP planned to be on vacation.</p> <p>Interview with the Director of Nursing (DON) and Administrator on August 8, 2012, at 4:30 p.m., in the family room, revealed PNP made weekly visits to the facility and the facility had alternate providers for the PNP. Continued interview</p>	F 319	<p>The DON, ADON or RN will conduct random audits of Physician orders for Psychiatric Evaluations to verify appropriate follow up beginning 9/1/12.</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, beginning in September, for three (3) months and recommendations for changes implemented, as appropriate.</p>	
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F 319  {F 323} SS=D	Continued From page 8 confirmed the facility failed to follow the physician's order for a psych evaluation for Resident #4, and the DON stated, "...Striking out is a new behavior for (Resident #4)..." 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 review of the facility's plan of correction, medical record review, observation, and interview, the facility failed to ensure safety devices were in place to prevent falls for one resident (#5) of six sampled residents.  The findings included:  Review of the facility's Plan of Correction from a complaint survey completed on June 25, 2012, with a correction date of July 13, 2012, revealed, "...Side rails have been raised x (times) 2 with mats on floor beside bed. Care plan has been updated with current safety precautions. Side rail assessments have been completed on all residents on (resident's floor)..."  Resident #5 (#5 for survey completed June 25, 2012) was admitted to the facility on October 7, 2010, with diagnoses including Vascular	F 319  {F 323}	F - 323 - Side rail assessment was updated by the ADON on 8/10/12 for Resident # 5.  The Physician order, Care Plan, resident visualization and Side rail assessment have all been reviewed for congruency by the DON and ADON between 8/10/12 and 8/24/12.  The RN staff education coordinator has re-educated the nursing staff on placement of side rails and other safety devices as indicated on the resident's plan of care. In-services began 8/23/12 and continued through 8/28/12 with all working nursing staff.	7/13/12 8/24/12

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{F 323}	<p>Continued From page 9 Dementia with Depression.</p> <p>Medical record review of a Side Rail Evaluation dated May 15, 2012, revealed the resident was unable to get out of bed safely and included, "...Interventions utilized...will communicate with family about removing full rails and replace with half rails..." Medical record review revealed no documentation regarding another Side Rail Evaluation.</p> <p>Medical record review of a Minimum Data Set dated June 19, 2012, revealed the resident was impaired with decision-making skills, totally dependent on staff for all activities of daily living, and had a history of falls.</p> <p>Medical record review of a care plan dated June 20, 2012, revealed, "...SAFETY PRECAUTIONS...Floor mats...at risk for falls...safety unawareness...Full side rails with padding to bed..."</p> <p>Medical record review of a physician's order dated April 30, 2012, revealed, "Mats at bedside for protection."</p> <p>Medical record review of nurse's notes revealed no documentation on or since July 13, 2012.</p> <p>Observation on August 8, 2012, at 9:18 a.m., revealed the resident asleep on a low bed, a 3/4 unpadded siderail on the right side of the bed was raised and the siderail on the left side of the bed was lowered. Continued observation revealed a mat on the floor on the left side of the bed and no mat on the right side of the bed.</p>	{F 323}	<p>The DON, ADON, and RN staff coordinator have re-educated all nursing staff on the proper verification of Physician orders to the Resident Care Plan. In-services began 8/23/12 and continued through 8/28/12 with all working nursing staff.</p> <p>The DON, ADON or RN will conduct random audits of residents care plans and visualize the resident for proper safety precautions beginning 8/22/12. Audits will be done on 10 residents per week for 4 weeks, then 10 residents per month for 3 months.</p> <p>The DON, ADON or RN will conduct random audits of resident care plans to ensure that appropriate Physician orders have been updated beginning 8/22/12. Audits will be done on 10 residents per week for 4 weeks, then 10 residents per month for 3 months.</p>	
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NAME OF PROVIDER OR SUPPLIER  ASSBURY 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 10</p> <p>Observation with Licensed Practical Nurse (LPN) #1 on August 8, 2012, at 9:20 a.m., revealed the resident on the bed and the left siderail on the resident's bed was not raised.</p> <p>Observation on August 8, 2012, at 10:23 a.m., revealed the resident on the bed and the left side rail was not raised.</p> <p>Interview with Certified Nursing Assistant (CNA) #1 on August 8, 2012, at 10:30 a.m., in the hallway outside the resident's room, revealed CNA #1 left the siderail down after providing care for the resident. Continued interview revealed the information regarding safety devices required by residents was available in a notebook, and CNA #1 stated, "...It (left siderail) stays down."</p> <p>Review of a list in a notebook "Restraints Bedrails" with CNA #1 on August 8, 2012, at approximately 10:35 a.m., in a nurse's station, revealed, "... (Resident #5) Bed lowest position - Bedrails Down x 2-Leftside Bedside mat x 1 (Half Rails)..."</p> <p>Interview with LPN #2 (the resident's nurse) on August 8, 2012, at 10:50 a.m., at a nurse's station, revealed safety precautions to prevent falls for Resident #5 included a low bed with the left siderail lowered.</p> <p>Interview with Nurse Practitioner (NP) #1 on August 8, 2012, at 11:07 a.m., revealed the facility attempted to reduce the number of residents requiring the use of siderails. NP #1 stated, "...feel like (Resident #5) would benefit from (the use of) two siderails..."</p>	{F 323}	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, beginning in September, monthly for three (3) months and recommendations implemented, as appropriate.		

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

FORM APPROVED  
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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  R-C 08/08/2012
NAME OF PROVIDER OR SUPPLIER  ASBURY PLACE AT MARYVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 2848 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}	Continued From page 11 Interview with the Director of Nursing on August 8, 2012, at 9:30 a.m., in the family room, revealed no assessment for use of siderails had been completed since May 15, 2012. Continued interview confirmed the facility failed to ensure safety devices were in place to prevent falls for Resident #5 and/or implement the plan of correction.	{F 323}			