

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

OTC 12/20/12

PRINTED: 11/21/2012
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 11/05/2012
--	--	--	---

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 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 – Resident # 2 remains a resident of Asbury Place, and has had no subsequent allegations of abuse.</p> <p>Subsequent abuse allegations have been reviewed, and thorough investigations have been completed by the Administrator.</p> <p>The Abuse Policy has been reviewed by the Administrator. The RN has re-educated all of the associates on the need to report abuse immediately. The Administrator has re-educated the management associates on the need to complete a thorough investigation.</p> <p>All abuse allegation investigations will be audited to determine that investigations are thorough and complete for the next 3 months by the Administrator.</p>	12/14/12
---------------	--	-------	---	----------

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X5) DATE 12/14/12

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.

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: 448017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2012
--	--	--	---

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 225	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, review of facility investigation, observation, and interview, the facility failed to thoroughly investigate an allegation of abuse for one resident (#2) of thirteen sampled residents.</p> <p>The findings included:</p> <p>Review of facility policy Number RS-NSG-041 most recently revised on April 3, 2005, revealed, "...Topic: Abuse/Neglect/Mistreatment..Alleged violations will be thoroughly investigated by the Director of Nursing (DON)..."</p> <p>Medical record review revealed the resident (#2) was admitted to the facility on December 8, 2011, with diagnoses including Rhabdomyolosis and Psoriatic Arthropathy.</p> <p>Medical record review of a History and Physical dated November 30, 2011, revealed, "...closed head injury...alert and oriented answered questions appropriately..." Medical record review of a Minimum Data Set dated September 11, 2012, revealed the resident was impaired with decision-making skills and dependent on staff for hygiene.</p> <p>Interview with the Director of Nursing (DON) on October 29, 2012, at 9:00 a.m., in the family room, revealed the facility had reported an allegation of verbal abuse regarding sampled Resident #2.</p> <p>Review of facility investigation (statement by</p>	F 225	<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 December, monthly for three (3) months and changes will be made based on recommendations, as appropriate.</p>	
-------	---	-------	--	--

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 11/05/2012
--	--	--	---

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 225	<p>Continued From page 2</p> <p>Certified Nursing Assistant - CNA) #1 dated October 24, 2012, revealed, "...on 10-21-12... (Alleged Perpetrator - AP)...telling (resident) that (resident) knew better than to smear (feces)...was a grown adult...and when (AP) was getting (resident) out of bed (resident) became combative by kicking...(Resident) started yelling at (AP)...(AP) told (resident)...If kept that up (Resident's) (expletive) would stay up until 11 p.m."</p> <p>Review of facility investigation (the AP's statement) dated October 24, 2012, revealed, "When I clock (clocked) in went to my floor. A housekeeper (#1) stop (stopped) me...said (resident) had (feces) all over...not cleaning (resident's) room until someone clean (cleaned) (resident) up...I clean (cleaned) (resident) up and try to get (resident) up..."</p> <p>Continued review of facility investigation revealed no statement from the referenced housekeeper..."</p> <p>Observation on November 1, 2012, at 2:58 p.m., revealed the resident utilized the call light, requested toileting assistance, and the assistance was provided.</p> <p>Interview with the resident on November 1, 2012, at 3:25 p.m., revealed the resident was disoriented to time, had never been mistreated, and had no complaints. Continued interview revealed the resident would rely on family to address any complaint that may occur.</p> <p>Interview with the Housekeeper #1 on November 5, 2012, at 1:22 p.m., revealed she was in the</p>	F 225		
-------	--	-------	--	--

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

PRINTED: 11/27/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 448017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2012
--	--	--	---

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 225

Continued From page 3
room while the AP provided care to the resident.

F 225

Interview with the DON on November 2, 2012, at 4:00 p.m., in the family room, revealed the facility's investigation did not include a statement from Housekeeper #1. Continued interview confirmed the facility failed to thoroughly investigate an allegation of abuse for Resident #2.

F 323
SS=D

C/O: #30674
483.25(h) FREE OF ACCIDENT
HAZARDS/SUPERVISION/DEVICES

F 323

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.

F 323 – Resident # 8's Care Plan has been reviewed and Fall Prevention interventions are complete.

12/14/12

This REQUIREMENT is not met as evidenced by:

Based on medical record review, review of facility investigation, observation, and interview, the facility failed to provide adequate supervision and/or safety device to prevent recurrent falls for one resident (#8) of thirteen sampled residents.

The findings included:

Resident #8 was admitted to the facility on November 9, 2001, with diagnoses including Vascular Dementia and Schizophrenia.

Medical record review of a Minimum Data Set

The care plans of residents at risk for falls have been reviewed and are complete, with new interventions added after a fall.

The Fall Prevention policy has been reviewed and revised. The RN has re-educated all nursing associates on the need to add a new intervention after each fall.

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

PRINTED: 12/27/2012
FORM APPROVED
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 448017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2012
--	--	--	---

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 4</p> <p>(MDS) dated June 6, 2012, revealed the resident was moderately impaired with decision-making skills and non-ambulatory, required limited assistance with transfers, and had a history of falls.</p> <p>Medical record review of a Fall Risk Assessment dated June 7, 2012, revealed a score of eight and included, "...4 or more...will be...care planned at risk..."</p> <p>Medical record review of the current care plan effective through December 12, 2012, revealed the risk for falls was addressed and interventions included a low bed. Medical record review of a care plan revision dated July 11, 2012, revealed, "...bed pressure sensor..."</p> <p>Medical record review of a nurse's note dated September 2, 2012, at 2:45 p.m., revealed, "found...on floor at bedside. Bed low position and bed alarm sounded. No injury...phone call to res (resident's) son...who requests that both siderails be up this evening when res (resident) in bed."</p> <p>Review of facility investigation dated September 2, 2012, revealed the resident fell out of bed and included, "...were bed rails present yes...R (right) down...successful fall..." Continued review revealed no documentation regarding a new intervention to prevent falls.</p> <p>Medical record review of a nurse's note dated September 3, 2012, at 7:45 p.m., revealed, "unwitnessed fall OOB (out of bed)...found lying on floor next to bed by CNA (Certified Nursing Assistant) who was right outside of room and heard bed alarm sound...hematoma to R (right)</p>	F 323	<p>The DON will audit 10 fall care plans weekly for 4 weeks, then monthly for 3 months to determine that new approaches have been added after each fall.</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 December, for three (3) months and recommendations for changes implemented, as appropriate.</p>	
-------	---	-------	---	--

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

PRINTED: 11/21/2012
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 11/05/2012
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 5</p> <p>forehead and scant blood R nostril...mat placed on floor at this time..." Medical record review of a nurse's note dated September 3, 2012, at 7:50 p.m., revealed, "...steristrip to small lac (laceration) underneath right nostril...(son)...said doesn't care what state has to say about it. This could have been prevented. order written per (Nurse Practitioner -NP for SR (siderail...)"</p> <p>Medical record review of a Nurse Practitioner's (NP) note dated September 3, 2012, revealed, "staff report (resident) was in bed with siderail down...heard noise...went...to check on (resident) and found in floor on R side...hematoma R forehead...tiny laceration under R nostril...knew son when he came in...lac cleaned with soap and water skin prep (preparation) steristrip..."</p> <p>Medical record of an Interdisciplinary Narrative Note dated September 6, 2012, revealed, "...reevaluated for siderail needs...siderail up per drs (doctor's) order."</p> <p>Observations on November 2, 2012, at 3:07 p.m. and November 5, 2012, at 9:10 a.m., revealed the resident in bed and the siderails raised.</p> <p>Interview with the MDS/Care Plan Coordinator on November 5, 2012, revealed she participated with review of the resident's falls and she stated, "...under the impression if successful fall with no injury there's nothing else we can do at that point..." Continued interview revealed no additional intervention to prevent falls was implemented following the resident's fall on September 2, 2012. Continued interview confirmed the facility failed to provide adequate supervision and/or safety device to prevent a fall</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 11/05/2012
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 6 with injury for Resident #8 on September 3, 2012.	F 323			
F 441 SS=D	<p>C/O: #30415</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as Isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and</p>	F 441	<p>F - 441 - Resident #13 was treated for C-diff toxin. All potentially contaminated items have been stored appropriately. Residents diagnosed with C-diff toxin have been identified and potentially contaminated items have been stored appropriately.</p> <p>The Infection Control - Isolation policy has been reviewed and revised. The RN has re-educated all nursing associates on the appropriate storage of potentially contaminated items.</p> <p>The DON will audit 5 rooms of residents diagnosed with C-diff to observe for appropriate storage of potentially contaminated items, weekly for 4 weeks then monthly for 3 months.</p>	12/14/12	

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 11/05/2012
--	--	--	---

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 441

Continued From page 7
transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

Based on review of facility policy, medical record review, observation, and interview, the facility failed to maintain a sanitary environment to prevent the development and transmission of infection for one resident (#13) of thirteen sampled residents.

The findings included:

Review of facility policy titled Equipment and Supplies Used During Isolation dated May, 22, 2003, revealed, "...supplies will be used to ensure that sanitary conditions are maintained during isolation...shall be stored and maintained in accordance with appropriate isolation precautions..."

Resident #13 was admitted to the facility on August 1, 2012, with diagnoses including Pneumonia.

Medical record review of a laboratory result dated August 10, 2012, revealed, "Clostridium Difficile (C-diff) toxin A+B positive (normal is negative).

Medical record review of a nurse's note dated August 11, 2012, at 7:00 p.m., revealed, "incont (incontinent) bowel @ (at) supper time found stool in floor of room and hallway..."

F 441

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 December, monthly for three (3) months and recommendations implemented, as appropriate.

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 11/05/2012
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)	(X6) COMPLETION DATE
F 441	<p>Continued From page 8</p> <p>Medical record review of a nurse's note dated August 22, 2012, revealed, "to (another floor within the facility)...new order to dc (discontinue) isolation with C-diff..." Medical record review of a nurse's note dated August 22, 2012, at 8:00 p.m., revealed, "wanders into others rooms...gets in other res beds..."</p> <p>Medical record review of a laboratory report dated September 3, 2012, revealed, "(C-diff) toxin A+B positive..."</p> <p>Medical record review of a Nurse Practitioner (NP) note dated September 3, 2012, revealed, "seen due to recurrent diarrhea. had just finished (antibiotic) and now with fever...liq (liquid) stool Incont..."</p> <p>Medical record review of a physician's progress note dated October 8, 2012, revealed recurrent bout with C-diff colitis. has been released from isolation..."</p> <p>Medical record review of a NP note dated October 11, 2012, revealed, "...still with diarrhea...recurrent C-diff. cont (continue) (antibiotic) qid (four times daily)...through 10-20, then...tid (three times daily) x 14 d (for 14 days), then...q12h (every 12 hours) x 14 d, then...qd (every day) x 14 d."</p> <p>Observation on November 5, 2012, at 12:48 p.m., revealed a posted sign outside the resident's room advised visitors to report to the nurse's station before entering the room.</p> <p>Observation on November 15, 2012, at 2:33 p.m., revealed the resident seated in a wheelchair and</p>	F 441		

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 11/05/2012
--	--	--	---

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 441	<p>Continued From page 9 fabric heel protectors (worn while in bed) on the floor in the corner of the room.</p> <p>Observation and interview with Licensed Practical Nurse #1 on November 5, 2012, at 2:36 p.m., revealed fabric heel protectors on the floor in the corner of the resident's room and confirmed the facility failed to maintain a sanitary environment to prevent the development or transmission of infection for Resident #13.</p> <p>C/O: #30363</p>	F 441		
-------	--	-------	--	--