

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

FORM APPROVED  
OMB NO. 0938-0391

*Copy OTC 11/4/13*

|   |  |  |   |
|---|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION<br><i>Poc #1</i> | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>445017 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>C<br>09/20/2013 |
|---|--|--|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>ASBURY PLACE AT MARYVILLE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2648 SEVIERVILLE RD<br>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 155<br>SS=D | <p><b>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES</b></p> <p>The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>The facility must comply with the requirements specified in subpart 1 of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>This STANDARD is not met as evidenced by: Based on review of the facility's Resident's Rights, medical record review, review of a facility investigation, and interview, the facility failed to permit a resident to refuse treatment for one resident (#1) of eight sampled residents.</p> <p>The findings included:</p> <p>Review of the facility's Resident's Rights provided by the Director of Nursing (DON) on September 13, 2013, revealed, "...Each resident has at least the following rights...To refuse treatment. The resident must be informed of the consequences of that decision. The refusal and its reason must</p> | F 155 | <p>F 155 – DON investigated this incident and self-reported the results of the investigation through the Unusual Incident Reporting System.</p> <p>All nursing staff have been re-educated by the Staff Development RN the ADON or the RN Supervisors on Resident Rights and how to respond when a resident refuses treatment.</p> <p>The DON, ADON or RN Supervisors will conduct random audits of 5 residents per week for 4 weeks, then 5 residents per month for 3 months to ensure that Resident Rights have been fulfilled.</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> | <p><i>2/20/13</i><br/><i>10/4/13</i></p> |
|---------------|--|-------|--|--|

|   |                               |                             |
|---|-------------------------------|-----------------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br><i>Alan J. Brown</i> | TITLE<br><i>Administrator</i> | (X8) DATE<br><i>9/30/13</i> |
|---|-------------------------------|-----------------------------|

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:<br><br><b>445017</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>09/20/2013</b> |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ASBURY PLACE AT MARYVILLE</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2648 SEVIERVILLE RD<br/>MARYVILLE, TN 37804</b> |
|--|---|

| (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 155 | <p>Continued From page 1<br/>be reported to the physician and documented in the resident's file..."</p> <p>Medical record review revealed Resident #1 was re-admitted to the facility on June 19, 2012, and diagnoses included Acute Kidney Failure, Multiple Sclerosis, Bipolar Disorder, Encephalopathy, and Psychosis.</p> <p>Medical record review of a Minimum Data Set dated December 26, 2012, revealed the resident's cognition was intact and the resident required total assistance with bed mobility, transfers, dressing, and hygiene.</p> <p>Medical record review of a physician's order dated February 1, 2013, revealed, "...DC PO (discontinue oral) Abilify - refuses to take. Abilify 9.75 mg IM (milligrams Intramuscular) for acute psychosis repeat in 2 hrs prn (hours as needed)...Maximum 30 mg daily..."</p> <p>Medical record review of a nurse's note dated February 14, 2013, at 4:00 p.m., revealed, "...c/o (complained of) chest pain. Called (Medical Doctor - M.D. #1) and adv (advised) of complaints. (M.D. #1)...stated to give PRN dose of Abilify IM. Adv (advised) had been refusing meds (medications) daily...' IM injection given in L (left) thigh."</p> <p>Medical record review of the next nurse's note dated February 14, 2013, at 6:30 p.m., revealed no documentation regarding refusal of the medication, informing the patient of the consequences of the decision to refuse, and/or notification of the physician of the patient's refusal prior to the injection. Continued review revealed,</p> | F 155 |  |  |
|-------|--|-------|--|--|

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:<br><br>445017 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br>C<br>09/20/2013 |
|---|--|--|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>ASBURY PLACE AT MARYVILLE |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2648 SEVIERVILLE RD<br>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 155   | Continued From page 2<br>"Follow-up from injection. Calm..."<br><br>Review of a witness statement (Director of Nursing's) in the facility's investigation dated February 15, 2013, revealed, "I spoke with (resident) per telephone about...(7:00 p.m.)...informed me (resident) was upset about something that happened yesterday...(M.D. #1)...had the nurse give...injection of Abilify last night and that (resident) did not want the medication...was given to (resident) by the nurse (Licensed Practical Nurse - LPN #1) and (Registered Nurse - RN#1) made the nurse give it..."<br><br>Telephone Interview with LPN #1 on September 17, 2013, at 10:00 a.m., revealed LPN #1 administered the injection on February 14, 2013, and LPN #1 stated, "...I called (M.D. #1)...(M.D. #1) said to give injection of Abilify...(RN #1) and I went in there. (Resident) refused. (RN #1) told me to put it in the top of (resident's) leg...I let...somebody talk me into doing something I knew was wrong."<br><br>Interview with the DON on September 17, 2013, at 3:00 p.m., in the facility's family room, revealed she learned of the patient's refusal of the injection from the patient on February 15, 2013. She stated, "...violated patient's rights." | F 155  |   |   |
| F 157<br>SS=D   | C/O: #31229<br>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)<br><br>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative  | F 157  |   |   |

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:<br><br>446017 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>C<br>09/20/2013 |
|--|--|--|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>ASBURY PLACE AT MARYVILLE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2648 SEVIERVILLE RD<br>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 157 | <p>Continued From page 3</p> <p>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:<br/>Based on review of the facility's Resident Rights, review of facility policy, medical record review, review of a facility investigation, and interview, the facility failed to notify the physician of a resident's refusal of medication for one resident (#1) of eight sampled residents.</p> <p>The findings included:</p> | F 157 | <p>F 157 – Physician for Resident #1- was notified of the injection given against the residents will on 2/15/13 by the Director of Nursing.</p> <p>The Physician Notification policy has been reviewed for accuracy.</p> <p>All nursing staff have been re-educated by the Staff Development RN, ADON or the RN Supervisors on the Physician Notification policy.</p> <p>The DON, ADON or RN Supervisor 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> | 10/4/13 |
|-------|--|-------|---|---------|

## CENTERS FOR MEDICARE &amp; MEDICAID SERVICES

OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>445017  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                |  | (X3) DATE SURVEY COMPLETED<br><br>C<br>09/20/2013 |
|---|---|---|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>ASBURY PLACE AT MARYVILLE |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2848 SEVIERVILLE RD<br>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 157   | <p>Continued From page 4</p> <p>Review of the facility's Resident's Rights provided by the Director of Nursing (DON) on September 13, 2013, revealed, "...Each resident has at least the following rights...To refuse treatment...The refusal and its reason must be reported to the physician..."</p> <p>Review of facility Policy Number: RS-NSG-022 titled Physician Notification and dated July 13, 2012, revealed, "...the physician will be notified about any change in resident condition according to Federal and State guidelines...Licensed personnel will convey the situation...in a concise and complete manner...Chief complaint of resident..."</p> <p>Medical record review revealed Resident #1 was re-admitted to the facility on June 19, 2012, and diagnoses included Acute Kidney Failure, Multiple Sclerosis, Bipolar Disorder, Psychosis, and Encephalopathy.</p> <p>Medical record review of a Minimum Data Set dated December 26, 2012, revealed the resident's cognition was intact and the resident required total assistance with bed mobility, transfers, dressing, and hygiene.</p> <p>Medical record review of a physician's order dated February 1, 2013, revealed, "...DC PO (discontinue oral) Abilify - refuses to take. Abilify 9.75 mg IM (milligrams Intramuscular) for acute psychosis repeat in 2 hrs pm (hours as needed)...Maximum 30 mg daily..."</p> <p>Medical record review of a nurse's note dated February 14, 2013, at 4:00 p.m., revealed, "...c/o</p> | F 157   | <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

FORWARD APPROVED  
OMB NO. 0938-0391

|  |  |  |   |
|--|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>445017 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>C<br>09/20/2013 |
|--|--|--|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>ASBURY PLACE AT MARYVILLE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2648 SEVIERVILLE RD<br>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 157 | <p>Continued From page 5</p> <p>(complained of) chest pain. Called (Medical Doctor - M.D. #1) and adv (advised) of complaints. (M.D. #1)...stated to give PRN dose of Abilify IM. Adv (advised) had been refusing meds (medications) daily...IM injection given in L (left) thigh."</p> <p>Medical record review of the next nurse's note dated February 14, 2013, at 8:30 p.m., revealed, "Follow-up from injection. Calm, but still upset..."</p> <p>Medical record review of a Nurse Practitioner's note dated February 15, 2013, revealed, "...Is upset that...received IM Abilify yesterday and says...did not want it even though (physician) ordered..."</p> <p>Medical record review of nurse's notes dated February 14, 2013, revealed no documentation the physician was notified regarding the patient's refusal of the medication prior to the injection.</p> <p>Review of facility investigation documentation (Director of Nursing's witness statement) dated February 15, 2013, revealed, "I spoke with (resident) per telephone about...(7:00 p.m.)...Informed me (resident) was upset about something that happened yesterday...Injection of Abilify last night and that (resident) did not want the medication...was given to (resident) by the nurse (Licensed Practical Nurse - LPN #1) and (Registered Nurse - RN#1) made the nurse give it..."</p> <p>Telephone interview with LPN #1 on September 17, 2013, at 10:00 a.m., revealed LPN #1 administered the injection on February 14, 2013, and LPN #1 stated, "...I called (M.D. #1)...(M.D. #1) said to give injection of Abilify...(Registered</p> | F 157 |  |  |
|-------|--|-------|--|--|

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:<br><br>445017 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                               | (X3) DATE SURVEY COMPLETED<br><br>C<br>09/20/2013 |
|---|---|--|---|-------------------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>ASBURY PLACE AT MARYVILLE |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2848 BEVIERVILLE RD<br>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 157   | Continued From page 6<br>Nurse RN #1) and I went in there. (Resident) refused. (RN #1) told me to put it in the top of (resident's) leg...I gave injection (resident) told me (resident) did not want..."   | F 157  | F226 - The Abuse policy has been reviewed by the Administrator and the DON. Policy is in compliance with Federal and State regulations.   | <del>2/20/13</del><br>10/4/13 |   |
| F 226<br>SS=D   | Interview with the DON on September 16, 2013, at 12:37 p.m., in the facility's family room, revealed the resident refused the injection of Ability on February 14, 2013. She stated, "...The resident was in (resident's) right mind...They did not let the doctor know the resident was refusing and gave it anyway."<br><br>C/O: #31229<br>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based review of facility policy, medical record review, review of a facility investigation, and interview, the facility failed to implement the abuse policy for one resident (#1) of eight sampled residents.<br><br>The findings included:<br><br>Review of facility Policy Number: RS-NSG-041 most recently revised July 1, 2010, revealed, "...When a person witnesses or suspects abuse, neglect or mistreatment of a resident...the person | F 226  | All nursing staff have been re-educated by the Staff Development RN the ADON or the RN Supervisors on the Abuse Policy.<br><br>Any allegations will be reviewed and audited by the Administrator. All submitted UIRS reports will be audited by the Administrator for compliance of the Abuse Policy. Audits will be effective for any reported incidents over the next 6 months.<br><br>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. |                               |   |

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:<br><br>445017 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br>C<br>09/20/2013 |
|---|---|--|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>ASBURY PLACE AT MARYVILLE |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2848 SEVIERVILLE RD<br>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 226   | <p>Continued From page 7</p> <p>must report it immediately to the DON (Director of Nursing) and Administrator of the facility..."</p> <p>Medical record review revealed Resident #1 was re-admitted to the facility on June 19, 2012, and diagnoses included Acute Kidney Failure, Multiple Sclerosis, Bipolar Disorder, Psychosis, and Encephalopathy.</p> <p>Medical record review of a Minimum Data Set dated December 26, 2012, revealed the resident's cognition was intact and required total assistance with bed mobility, transfers, dressing, and hygiene.</p> <p>Medical record review of a physician's order dated February 1, 2013, revealed, "...DC PO (discontinue oral) Abilify - refuses to take. Abilify 9.75 mg IM (milligrams intramuscular) for acute psychosis repeat in 2 hrs prn (hours as needed)...Maximum 30 mg daily..."</p> <p>Medical record review of a nurse's note dated February 14, 2013, at 4:00 p.m., revealed, "...c/o (complained of) chest pain. Called (Medical Doctor M.D. #1) and adv (advised) of complaints. (M.D. #1)...stated to give PRN dose of Abilify IM. Adv (advised) had been refusing meds (medications) daily...IM injection given in L (left) thigh."</p> <p>Medical record review of the next nurse's note dated February 14, 2013, at 6:30 p.m., revealed, "Follow-up from injection. Calm, but still upset..."</p> <p>Review of facility investigation documentation (statement of the Director of Nursing) dated February 15, 2013, revealed, "I spoke with</p> | F 226  |   |                      |   |

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

|  |  |  |   |
|--|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>445017 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>C<br>09/20/2013 |
|--|--|--|---|

|   |   |
|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>ASBURY PLACE AT MARYVILLE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2648 SEVIERVILLE RD<br>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 226 | <p>Continued From page 8</p> <p>(resident) per telephone about...(7:00 p.m.)... (resident) informed me (resident) was upset about something that happened yesterday...the nurse give...Injection of Abilify last night and that (resident) did not want the medication...was given to (resident) by the nurse (Licensed Practical Nurse - LPN #1) and (Registered Nurse - RN #1) made the nurse give it..."</p> <p>Review of facility investigation documentation (an e-mail from RN #1 to the DON and a statement signed by Licensed Practical Nurse (LPN #1)) dated February 16, 2013, revealed LPN #1 administered an IM injection despite the patient's refusal on February 14, 2013, and RN #1 was present when the injection was administered.</p> <p>Telephone interview with Licensed Practical Nurse (LPN #1) on September 17, 2013, at 10:00 a.m., revealed LPN #1 administered the injection on February 14, 2013, and LPN #1 stated, "... (M.D. #1) said to give injection of Abilify... (Registered Nurse RN #1) and I went in there. (Resident) refused. (RN #1) told me to put it in the top of (resident's) leg...I gave injection (resident) told me (resident) did not want...I let...somebody talk me into doing something I knew was wrong."</p> <p>Interview with the Director of Nursing on September 17, 2013, at 3:00 p.m., in the facility's family room, revealed LPN #1 nor RN #1 reported the incident to her. Continued interview revealed she learned the resident was administered an injection on February 14, 2013, despite the resident's refusal, from the patient on February 15, 2013. Continued interview confirmed the facility failed to implement the abuse policy for Resident #1 on February 14, 2013.</p> | F 226 |  |  |
|-------|---|-------|--|--|