

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

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PRINTED: 12/16/2011
FORM APPROVED
OMB NO. 0938-0391

JAN 17 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/14/2011
NAME OF PROVIDER OR SUPPLIER ALAMO NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 580 W MAIN STREET ALAMO, TN 38001	
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F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and interview, it was determined the facility failed to revise or update the care plan for seizure disorder and seizure safety precautions for 1 of 18 (Resident #14) sampled residents. The findings included: Review of the facility's "Care Plan Policy" documented, "...Care plans should be reviewed and revised as often as necessary in order to reflect the resident's current status. Goals and	F 280	1. On 12/14/11 Resident #14's care plan was reviewed and revised by the Care Plan Coordinator to include seizure safety precautions. 2. On 12/15/11 all residents medical records with diagnosis of seizure disorder was reviewed, by the Director of Nursing and Staff registered nurse, to ensure seizure precautions were listed on the care plan. 3. On 12/14/11 Administrator and Director of Nursing reviewed the care plan policy for needed revisions. On 12/14/11 the Care Plan Coordinators were in serviced by the Administrator and Director of Nursing regarding the care planning process to reflect resident's current status. 4. The Director of Nursing or designee will audit 5% of facility census of care plans weekly for 2 months, then 10% monthly for 5 months, and then 5% monthly for 5 months by the use of an audit tool. Results of care plan audits will be reported quarterly to the Performance improvement committee.	12/16/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Edward Todd McBrayer, RNHA TITLE Administrator (X6) DATE 12/28/11

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their 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 280	<p>Continued From page 1</p> <p>interventions should be conveyed that will help the resident attain or maintain the highest practicable level of physical, mental, and psychosocial well being..."</p> <p>Medical record review for Resident #14 documented an admission date of 5/2/08 and readmission date 9/24/10 with diagnoses of Cerebrovascular Accident with Right Hemiparesis with Significant Expressive Aphasia, Insulin Dependent Diabetes Mellitus and Hypertension. Review of the hospital history and physical dated 10/22/11 through (-) 11/1/11 documented, "...Seizure disorder..." Review of the physician's orders signed 12/1/11 documented, "...Levetiracetam 500 mg [milligram] take 1 tablet po [by mouth] (sub Keppra) once a day for seizures..." Review of the care plan dated 10/20/11 and updated 12/12/11 contained no documentation of seizure disorder or seizure safety precautions.</p> <p>During an interview in the Minimum Data Set (MDS) office on 12/14/11 at 10:20 AM, the Director of Nursing (DON) was asked to review Resident #14's medical record. The DON stated, "...No, there is no seizure disorder or seizure safety precautions documented on the care plan... it should include maintain patent airway, stay beside resident until seizure is over..."</p>	F 280		
F 283 SS=D	<p>483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS</p> <p>When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of</p>	F 283	<p>1. Discharge summary for resident #16 and #18 was revised to include discharge diagnoses and more extensive recapitulation of residents' stay.</p> <p>2. On 12/16/11 the Social Service staff was in-serviced by the</p>	12/16/11

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F 283	Continued From page 2 the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to ensure each resident discharged from the facility had a recapitulation of the resident's stay for 2 of 2 (Residents #16 and 18) discharged residents reviewed. The findings included: 1. Medical record review for Resident #16 documented an admission date of 10/24/11 with diagnoses of Syncope and Collapse, Atrial Fibrillation, Osteoporosis, Irritable Bowel Syndrome, Hypertension, Esophageal Reflux and Depression. Review of the "Record of Discharge" documented a discharge date of 11/18/11 and no recapitulation of the resident's stay. 2. Medical record review for Resident #18 documented an admission date of 10/17/11 with diagnoses of Joint Replaced Hip, Osteoarthros, Hypothyroidism, Hypertension and Anxiety. Review of the "Record of Discharge" documented a discharge date of 11/16/11 and no recapitulation of the resident's stay. 3. During an interview in the Minimum Data Set office on 12/14/11 at 2:40 PM, the Director of Nursing confirmed there is no recapitulation of the resident's stay documented upon discharge.	F 283	Director of Nursing and Administator regarding the proper process and information to include in the discharge summary. 3. The Administrator will audit discharge summaries monthly for 12 months and report results of audit to the Performance Improvement Committee quarterly.	12/16/11
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309	1. a) On 12/14/11 resident #2	12/22/11

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F 309
SS=D

Continued From page 3
HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review and interview, it was determined the facility failed to follow the bowel movement (BM) protocol for 3 of 18 (Residents #2, 15 and 18) sampled residents.

The findings included:

1. Review of the facility's "BM Policy" documented, "...if a resident has no bowel movement in 3 days, 3-11 shift will administer laxative per standing order..."
2. Medical record review for Resident #2 documented an admission date of 6/23/08 with diagnoses of Multiple Myeloma, Diabetes Mellitus, Urethral Stricture, Urinary Retention and Hypertension. Review of the "NURSE AIDE'S SIGNATURE SHEET" had no BM documented on 10/2/11, 10/3/11, 10/4/11, 10/8/11, 10/9/11, 10/10/11, 10/20/11, 10/21/11, 10/22/11, 11/2/11, 11/3/11 and 11/4/11. Review of the "MEDICATION RECORD" for October and November 2011 had no laxative documented as being given on the third day of no BM on 10/4/11,

F 309

record of bowel elimination was reviewed and no laxatives were indicated, per physician's orders.

b) On 12/14/11 resident #15 record of bowel elimination was reviewed and no laxatives were indicated, per physician's orders.

c) Resident #18 was discharged on 11/6/11.

2. On 12/15/11 all residents' bowel elimination records were reviewed by nursing staff with laxatives administered as indicated, per physician's order.
3. On 12/16/11, the policy for monitoring bowl elimination was reviewed for needed revisions by the Administrator, Director of Nursing, and the Assistant Director of Nursing. On 12/22/11 all licensed nursing staff (LPN/RN) was in-serviced regarding the procedure of laxative administration and proper monitoring of bowel elimination.
4. Bowel elimination/intervention records will be audited by the Director of Nursing or designee daily for two months, then weekly for 5 months and then monthly for 5 months. The results of bowel

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F 309	<p>Continued From page 4 10/10/11, 10/22/11 and 11/4/11 as per the facility's policy.</p> <p>During an interview in the Minimum Data Set (MDS) office on 12/14/11 at 11:25 AM, the Director of Nursing (DON) confirmed no laxative had been given on the third day for no BM as per the facility's policy.</p> <p>3. Medical record review for Resident #15 documented an admission date of 8/29/03 with diagnoses of Macular Degeneration, Presenile Dementia, Depressive Disorder and Hypothyroidism. Review of the "NURSE AIDE'S SIGNATURE SHEET" had no BM documented on 9/7/11, 9/8/11, 9/9/11, 9/10/11, 9/21/11, 9/22/11, 9/23/11, 9/24/11, 9/28/11, 9/29/11, 9/30/11, 10/29/11, 10/30/11 and 10/31/11. Review of the "MEDICATION RECORD" for September and October 2011 had no laxative documented on the third day of no BM on 9/10/11, 9/24/11, 9/30/11 and 10/31/11 as per the facility's policy.</p> <p>During an interview in the MDS office on 12/14/11 at 11:25 AM, the DON confirmed no laxative had been given on the third day of no BM as per the facility's policy.</p> <p>4. Medical record review for Resident #18 documented an admission date of 10/17/11 with diagnoses of Joint Replaced Hip, Osteoarthritis, Hypothyroidism, Hypertension and Anxiety. Review of the "NURSE AIDE'S SIGNATURE SHEET" had no BM documented on 10/28/11, 10/29/11, 10/30/11 and 10/31/11. Review of the "MEDICATION RECORD" for October 2011 had no laxative documented as being given on the</p>	F 309	elimination/intervention audits will be reported to the Performance Improvement committee.	
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F 309 Continued From page 5
third day of no BM on 10/31/11 as per the facility's policy.

F 309

During an interview in the MDS office on 12/14/11 at 2:40 PM, the DON confirmed no laxative had been given on the third day of no BM as per the facility's policy.

F 323
SS=D 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.

1. a) On 12/12/2011 water heater #7 was corrected at 11:45a.m. by maintenance supervisor. On 12/12/11 at 12:30 pm, 1:00pm, 2:00pm, 3:30pm the water temperatures were checked in the south side bathroom and south shower room and the temperature was found to be within acceptable range. On 12/13/2011 at 06:30a.m., the maintenance supervisor checked water temperatures in the south side bathroom and south shower room and the temperature was found to be within the acceptable range.
b) Water heater #2. On 12/12/11 the staff was notified of water temperatures in rooms 11,15,18 and 20 and instructed not to use water in this area until notified. Signs were placed in these bathrooms indicating not to use water in this area. Maintenance was informed and immediately began servicing boiler. At 7:45 pm the completion/repair of boiler

12/14/11

This REQUIREMENT is not met as evidenced by:

Based on observation and interview, it was determined the facility failed to maintain safe hot water temperatures in resident areas for 2 of 7 (water heaters #2 and 7) water heaters.

The findings included:

Observations of the hot water temperatures on 12/12/11 revealed the following:

- a. Southside resident restroom (water heater #7): 134 degrees Fahrenheit (F) at 9:15 AM.
- b. Southside shower room (water heater #7): 128 degrees F at 9:35 AM.
- c. Southside resident restroom (water heater #7): 130 degrees F at 11:20 AM.
- d. Westside resident restroom adjoining rooms 11 and 15 (water heater #2): 140 degrees F at

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F 323	<p>Continued From page 6</p> <p>1:45 PM. e. Westside resident restroom adjoining rooms 18 and 20 (water heater #2): 120 degrees F at 1:47 PM. f. Westside resident restroom adjoining rooms 11 and 15 (water heater #2): 140 degrees F at 2:25 PM.</p> <p>During an interview on the South-side hall near the beauty shop on 12/12/11 at 9:45 AM, the Maintenance Supervisor was asked about the hot water temperatures. The Maintenance Supervisor confirmed that safe water temperature for resident use should be below 120 degrees F and the water heater settings are adjusted at the individual water heaters supplying each hall.</p> <p>F 328 SS=D 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure residents received proper treatment for respiratory care by not ensuring</p>	F 323	<p>was reported to administator. Temperatures were obtained from sinks in rooms 11,15,18 and 20 the temperature was 112-114°F. The water temperatures were checked every hour in rooms 11-15 and 17-19 and random room(s) on the unit until 11:00pm. At 11:00pm the staff was advised that the sinks were available for use. Beginning at 11:00pm water temperatures were conducted every two hours during rounds until 6 a.m. on 12/13/11 and the water temperatures were within range.</p> <p>2. Water temperatures will be monitored and recorded at a minimum of 5 times weekly by maintenance supervisor or designee in random resident care areas. On 12/14/11 the Maintenance staff was in-serviced by Administrator regarding environmental safety precautions.</p> <p>3. Water temperatures will be monitored by the maintenance supervisor or the assistance maintenance supervisor at a minimum of 5 times a week in random resident care areas. Water temperatures will be reported to the Performance Improvemnt Committee.</p>	

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F 328	<p>Continued From page 7</p> <p>there was a physician's order for continuous oxygen, oxygen was administered at the physician's prescribed rate and there was no care plan for oxygen therapy for 2 of 4 (Residents #10 and 14) sampled residents receiving oxygen therapy.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility's "Care Plan Policy" documented, "...Care plans should be reviewed and revised as often as necessary in order to reflect the resident's current status. Goals and interventions should be conveyed that will help the resident attain or maintain the highest practicable level of physical, mental, and psychosocial well being..." 2. Medical record review for Resident #10 documented an admission date of 2/10/04 with diagnoses of Congestive Heart Failure, Chronic Anemia, Hypertension and Depressive Disorders. Review of the recertification orders signed 12/8/11 documented Oxygen (O2) at 3 liters per minute (L/M). Review of the care plan dated 10/27/11 documented no interventions for oxygen. <p>Observations in Resident #10's room on 12/12/11 at 12:00 PM, 2:40 PM, 5:05 PM and on 12/13/11 at 8:45 AM and 10:50 AM, revealed Resident #10 receiving O2 at 2L/M. The oxygen was not being administered at the physician's prescribed rate of 3 L/M</p> <p>During an interview at nurse's station #3 on 12/14/11 at 10:35 AM, Nurse #2 was asked about the care plan for O2. Nurse #2 confirmed that</p>	F 328	<ol style="list-style-type: none"> 1. a) On 12/14/11 the care plan was revised for resident #10 to reflect oxygen therapy. b) On 12/14/11 oxygen via nasal cannula was discontinued on resident #14. 2. a) On 12/15/11 all medical records of residents who have an order for oxygen therapy were reviewed, to ensure oxygen therapy was reflected in the care plan. b) On 12/14/11 the Administrator and Director of Nursing reviewed the care plan policy and oxygen therapy policy for needed revisions. c) On 12/14/11 the care plan coordinator(s) were in-serviced by the Administrator and the Director of Nursing regarding care plan process to reflect the resident's current status. d) On 12/22/11 all licensed nursing staff (RN, LPN) was in-serviced by the Director of Nursing regarding policy of oxygen therapy and MD orders. 3. The Director of Nursing or designee will audit 5% of facility census of care plans weekly for 2 months, then 10% monthly for 5 months then 5% monthly for 5 months by the use of an audit tool. Oxygen therapy will be 	12/22/11

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F 328 Continued From page 8
Resident #10 had an order for O2 therapy and stated, "...I don't see it [O2 on the care plan] ...It [O2] should be on there [the care plan]..."

3. Medical record review for Resident #14 documented an admission date of 5/2/08 and readmission date 9/24/10 with diagnoses of Cerebrovascular Accident with Right Hemiparesis with Significant Expressive Aphasia, Insulin Dependent Diabetes Mellitus and Hypertension. Review of the physician's orders signed 12/1/11 contained no order for continuous oxygen therapy. Review of the facility's "24 Hour Skilled Nursing Documentation Sheet" dated 12/1/11 through 12/13/11 documented, "...Oxygen continuous 2- [to] 3 liter/minutes 98% O2 Sat [saturation]..." Review of the care plan dated 10/20/11 and updated 12/12/11 contained no documentation of oxygen therapy.

Observations in Resident #14's room on 12/12/11 at 9:15 AM and 2:50 PM and on 12/14/11 at 8:40 AM, 9:15 AM and 10:55 AM, revealed Resident #14 lying in bed receiving O2 at 2 L/M.

During an interview in the Minimum Data Set office on 12/14/11 at 10:20 AM, the Director of Nursing (DON) was asked to review Resident #14's medical record. The DON stated, "...The nurse notes stated she [Resident #14] is on continuous oxygen... no, there is no order for continuous oxygen and oxygen therapy is not on the care plan..."

F 328 monitored daily for two months, then weekly for 5 months, and then monthly for 5 months. The Performance Improvement Nurses will monitor the effectiveness of these audits monthly and report to the Performance Improvement Committee quarterly.

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