

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

JAN 30 2014

PRINTED: 01/26/2014
FORM APPROVED
OMB NO. 0938-0391

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 01/15/2014
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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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(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
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F 164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to provide privacy for residents' when forms with resident's names were placed in a trash can instead of being shredded at 1 of 3 (South Side Nurses' Station) nurses' stations.</p>	F 164	<p>F164 483.10(e) 483.75(l)(4) Personal Privacy/Confidentiality of Records SS = D</p> <p>Requirement: The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Corrective Action:</p> <ol style="list-style-type: none"> Staff at the South South Nurse's Station were inserviced on 1/15/14 regarding the residents' right to personal privacy and confidentiality of his or her personal and clinical records and the importance of clinic record confidentiality. Maintenance was inserviced on 1/15/14. The administrator in serviced all staff on 1/25/14 to confirm that all HIPAA applicable records shall be destroyed by burning, shredding or other effective methods in keeping the records confidential. Director of Nursing or designee will monitor the confidentiality of the residents clinical records weekly x's 4 weeks, monthly x's 3 months, then quarterly x's 2. The Performance Improvement Nurses will monitor the effectiveness of these audits monthly and report to the Performance Improvement Committee quarterly. <p>FOR CLARIFICATION PURPOSES: The Performance Improvement Committee consists of Medical Director, Administrator, Director of Nursing, Performance Improvement Nurses, Staff Trainer, Therapy, Dietary, Social Services, Housekeeping, Maintenance and Activities Coordinator. Different members of the committee will participate depending on the nature of the</p> <p>Completion Date: 1/25/14</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Donald J Jones</i>	TITLE <i>Admin</i>	(X6) DATE <i>1/29/14</i>
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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 164	<p>Continued From page 1</p> <p>The findings included:</p> <p>Review of facility's "Confidentiality of Information... Policy Interpretation and Implementation" policy documented, "...The facility will safeguard all resident's records, whether medical, financial, or social in nature, to protect the confidentiality of the information..."</p> <p>Observations at the south side nurses' station on 1/14/14 at 10:30 AM, revealed a trash can sitting outside the nurse's station next to the shredder and contained lists with residents names on them.</p> <p>During an interview at the south side nurses' station on 1/14/14 at 10:30 AM, Nurse #1 confirmed the papers had residents names. Nurse #1 was asked what their policy was on disposing of resident's information. Nurse #1 stated, "...this information should have been shredded..."</p> <p>During an interview in the Director of Nursing's (DON) office on 1/15/14 at 9:14 AM, the DON was asked what her expectations were for staff when disposing of resident information or resident rosters were. The DON stated, "...a black marker is used to draw through the patient's name when disposing a patient's medication bubble pack and any patient information or rosters should be shredded..."</p>	F 164		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be</p>	F 280		

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F 280	<p>Continued From page 2</p> <p>incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, review of incidents, observation and interview, it was determined the facility failed to revise the care plan to reflect new interventions implement after a fall for 2 of 15 (Residents #7 and #93) sampled residents of the 31 residents included in the stage 2 review.</p> <p>The findings included:</p> <p>1. Review of the facility's "Fall Risk Program Introduction For Residents and Families" policy documented, "...Addressing specific fall causes is the number one way to minimize the severity of fall injuries and frequency of all falls... When assessments have been completed appropriate interventions will be determined, once the risk</p>	F 280	<p>F280 483.20(d)(3), 483.10(k)(2) SS =D Requirement: The resident has the right, unless adjudged incompetent or otherwise found to incapacitated under the laws of the State, to participate in planning car and treatment or changes in care and treatment. Corrective Action: 1. Falls check list was provided to the Performance Improvement Nurse to ensure that all tasks and/or interventions were completed for proper documentation on the care plan. 2. The Performance Improvement Nurse and the Minimum Data Set (MDS) Coordinators were inserviced on 1/15/14 regarding proper documentation of fall interventions and ensuring that proper interventions are on the care plan post incident. 3. The Director of Nursing or designee will monitor care plans to ensure fall interventions were updated timely daily x's 4 weeks, weekly x's 4 weeks, then monthly x's 2 months. 4. The results of the audits will be reviewed monthly by the Performance Improvement Nurse and reported to the Performance Committee quarterly. FOR CLARIFICATION PURPOSES: The Performance Improvement committee consists of Medical Director, Administrator, Director of Nursing, Performance Improvement Nurse, Staff Trainer, Therapy, Dietary, Social Services, Housekeeping, Maintenance and Activities Coordinator. Different members of the committee will participate depending on the nature of the</p> <p>Completion Date: 1/17/14</p>		

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F 280

Continued From page 3
factors have been identified..."

Review of the facility's "Care Plan Policy documented, "...Care plans should be reviewed and revised 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 #7 documented an admission date of 02/20/09 with a re-admission date of 11/16/11 with diagnoses of Dementia, Dizziness and Giddiness, Alzheimer's Disease, Senile Dementia, Hypertension, Schizo affective Disorder, Paralysis Agitans and Anxiety.

Review of the "Incident Log" documented falls on 3/8/13, 4/9/13, 5/15/13, 5/17/13, 6/6/13, 11/14/13 and 12/16/1, with no injuries. Review of the "POST-INCIDENT ACTIONS" form dated 11/14/13 documented, "...Immediate Post-Incident Action: INSTRUCTED CNA [Certified Nursing Assistant] TO USE RESIDENT'S [Resident's] WALKER FOR ALL AMBULATION AND GAIT BELT FOR ALL TRANSFERS [Transfers]. Immediate Actions Taken: RESIDENT SHOES REPLACED WITH NONSKID SOLE SHOES AND STAFF INSTRUCTED TO USE WALKER AT ALL TIMES..." The care plan dated 6/6/13 did not include these interventions that had been implemented.

Observations in Resident #7's room on 1/13/14 at 3:00 PM, 1/14/14 at 8:05 AM and 4:00 PM, revealed Resident #7 seated in a large recliner with a chair alarm in place.

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F 280	<p>Continued From page 4</p> <p>During an interview in room 38 on 1/14/14 at 4:15 PM, the Minimum Data Set (MDS) Coordinator #1 was asked if there was an intervention on the care plan for the 11/14/13 fall. The MDS Coordinator #1 stated, "...I can't tell a lie, couldn't find the update on the care plan..."</p> <p>3. Medical record review for Resident #93 documented an admission date of 10/15/12 with diagnoses of Ataxia, Muscle Weakness, Senile Dementia, Hypertension and Diabetes Mellitus. Review of the quarterly MDS documented brief interview for mental status score of 99, indicating the resident was unable to complete the interview because the resident was severely cognitively impaired.</p> <p>Review of the "Resident Incident Report" dated 1/5/13 documented, "...SPITTING IN GARBAGE CAN FELL OVER TO FLOOR ON LEFT SIDE SMALL ST [Skin Tear] TO L [Left] THUMB SMALL BLEEDING..." The care plan dated on 12/26/13 did not include an intervention for the fall on 1/5/13.</p> <p>During an interview in room #38 on 1/14/14 at 3:00 PM, the MDS Coordinator #1 was asked when there is a fall should there be revised documentation on the care plan to reflect the intervention. The MDS Coordinator #1 stated, "We just started putting the date on some of them [interventions]..."</p>	F 280		
F 371 SS=D	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local</p>	F 371		

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F 371	<p>Continued From page 5 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure food was dated when opened and used by the best dates on 2 of 3 (1/13/14 and 1/14/14) days of the survey.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Review of the facility's "Food Receiving and Storage" policy documented, "...Foods shall be received and stored in a manner that complies with safe food handling practices... All foods stored in the refrigerator or freezer will be covered, labeled and dated ("use by" date)..." Observations in the walk-in freezer revealed the following: <ol style="list-style-type: none"> On 1/13/14 at 12:45 PM - a bag of unopened corn dogs with no expiration date. On 1/13/14 at 12:45 PM and 1/14/14 at 9:35 AM - an opened bag of chicken breasts and an opened bag of Salisbury steaks with no open date or expiration date on the packages. <p>During an interview in the walk-in freezer on 1/14/14 at 9:40 AM, the Certified Dietary Manager (CDM) was asked about the open and expirations dates not being on open packages. The CDM stated, "...I don't want to lie and will start putting</p>	F 371	<p>F-371 483.25(i)Food Procure, Store/Prepare/Serve - Sanitary SS=D</p> <p>Requirement: The facility must ensure procure food from sources approved or considered satisfactory by Federal, State or local authorizes; and store, prepare, distribute and serve food under sanitary conditions.</p> <p>Corrective Action:</p> <ol style="list-style-type: none"> All open containers were reviewed for proper labels and dates by the Dietary Supervisor. The unopened bag of corn dogs, the opened bag of chicken and the opened bag of Salisbury steaks were all labeled by the Dietary Supervisor. All open containers will be dated and sealed during storage. The Dietary Supervisor inserviced all dietary staff on proper dating and labeling of items on 1/15/14. The Dietary Supervisor or designee will monitor items for labeling and dating daily. The results of the audits will be reviewed monthly by the Performance Improvement Nurse and reported to the Performance Improvement Committee quarterly. <p>FOR CLARIFICATION PURPOSES: The Performance Improvement committee consists of Medical Director, Administrator, Director of Nursing, Performance Improvement Nurse, Staff Trainer, Therapy, Dietary, Social Services, Housekeeping, Maintenance and Activities Coordinator. Different members of the committee will participate depending on the nature of the</p> <p>Completion Date: 1/15/14</p>	
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F 371	Continued From page 6 dates on packages..." 3. Observations in the dry storage room on 1/14/14 at 11:35 AM, revealed a large can of Apricots, Fruit Cocktail, Sliced Apples and Mandarin Oranges with no expiration dates. During an interview in the dry storage room on 1/14/14 at 11:40 AM, the CDM was asked about the cans not having expiration dates. The CDM stated, "...dates may be on the boxes that the cans are taken out of..."	F 371		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined he facility failed to ensure assessments were accurate for 1 of 15 (Resident #7) sampled residents of the 31 residents included in the stage 2 review.	F 514		

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F 514	<p>Continued From page 7 The findings included:</p> <p>Medical record review for Resident #7 documented an admission date of 02/20/09 with a re-admission date of 11/16/11 with diagnoses of Dementia, Dizziness and Giddiness, Alzheimer's Disease, Senile Dementia, Hypertension, Schizo affective Disorder, Paralysis Agitans and Anxiety. Review of the "Monthly Summary" forms dated 5/26/13, 6/30/13, 8/25/13, 9/29/13, 11/29/13 and 12/28/13 documented Resident #7 with limited range of motion on both sides for upper and lower extremities. Review of the "Monthly Summary" forms dated 6/21/13 and 10/28/13 documented Resident #7 with no limitations in range of motion on both sides for upper and lower extremities. Review of the "Monthly Summary" forms dated 7/28/13 documented Resident #7 with limitations in range of motion on both sides for upper extremities.</p> <p>During interview at nurses' station #3 on 1/15/14 at 9:05 AM, Nurse #2 was asked about the discrepancies of the range of motion on the monthly summaries. Nurse #2 stated, "... [Resident #7] has good days and bad days... should be how they are for the month..."</p>	F 514	<p>F514 483.75(I)(1) SS = D Requirement: The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are completed; accurately documented; readily accessible and systematically organized. Corrective Action:</p> <ol style="list-style-type: none"> 1. The Director of Nursing reviewed "Resident #7" clinical record for accuracy and discrepancies. The clinic record was updated to reflect residents current condition. 2. Nursing staff was inserviced on 1/20/14 regarding completing monthly summaries correctly by comparing the previous monthly summary and care plan to note any changes in the resident's condition to ensure accuracy. 3. The Director of Nursing and/or designee will monitor the monthly summaries monthly x's 6 months. 4. The Performance Improvement Nurses will monitor the effectiveness of these audits monthly and report to the Performance Improvement Committee quarterly. <p>FOR CLARIFICATION PURPOSES: The Performance Improvement Committee consists of Medical Director, Administrator, Director of Nursing, Performance Improvement Nurse, Staff Trainer, Therapy, Dietary, Social Services, Housekeeping, Maintenance and Activities Coordinator. Different members of the committee will participate depending on the nature of the Completion Date: 1/31/14</p>	

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