

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

PRINTED: 04/29/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445470	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/08/2009
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NAME OF PROVIDER OR SUPPLIER  ARBOR PLACE OF PURYEAR	STREET ADDRESS, CITY, STATE, ZIP CODE 223 W CHESTNUT, PO BOX 306 PURYEAR, TN 38251
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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 309 SS=D	<p>483.25 QUALITY OF CARE</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, it was determined the facility failed to follow a physician's order for thickened liquids and failed to obtain an order for cleansing a wound for 2 of 10 (Residents #3 and 6) sampled residents.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. Medical record review for Resident #3 documented an admission date of 4/30/05 with diagnoses of Diabetes Mellitus, Anemia, Peripheral Vascular Disease, Depression, Syncope, Obesity, and Pressure Ulcer. Review of the physician's order dated 4/3/09 documented "...Apply Bactroban ointment to wound of left heel &amp; [and] then apply sterile dressings and coban twice daily..."</li> </ol> <p>Observations in Resident #3's room on 4/8/09 at 9:30 AM, revealed Resident #3 seated in a wheelchair at the bedside with her left foot elevated on a chair placed in front of her. Nurse #3 gloved, removed the old dressing from Resident #3's left heel, sprayed Saf Clens wound cleanser onto a 4 by (x) 4 gauze, and cleansed Resident #3's left heel. Nurse #3 cleansed the</p>	F 309	<p>F309</p> <p>Resident #3 will have wound care per MD orders. Specific orders as prescribed by the MD will be documented on the treatment sheet and followed per nurse doing the treatment and signed off.</p> <p>Wound care will be monitored by the Director of Nurse's or her designee Q month.</p> <p>The Director of Nurse's will In service all nursing staff (RN&amp;LPN) on proper wound care and following MD orders as specifically ordered. Each nurse providing care will sign off procedure on treatment sheet.</p> <p>Tag will be monitored by Quality Assurance Committee monthly until next annual survey.</p>	4-21-09 4-25-09
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE <i>Jeanne Numbrell</i>	TITLE INHA	(X6) DATE 5/6/09
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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 the 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 309	<p>Continued From page 1</p> <p>wound without a physician's order to use Saf Clens wound cleanser.</p> <p>During an interview at the nurses' station on 4/8/09 at 9:28 AM, Nurse #3 stated, "...I don't have an order to clean it [wound], but I'm going to [clean it]..."</p> <p>2. Medical record review for Resident #6 documented a diagnoses of Alzheimer's Disease, Organic Brain Syndrome, Chronic Coronary Arteriosclerosis, Arteritis, Endarteritis, Atheroma, Sclerosis, Stricture, Chronic Obstructive Pulmonary Disease, Chronic Airway Obstruction, Insomnia and Failure to Thrive. Review of a physician's order dated 2/5/09 documented, "PUREED DIET WITH NECTAR- THICKENED LIQUIDS."</p> <p>Observations in Resident #6's room on 4/6/09 at 9:00 AM, revealed 2 containers of honey consistency water in a cooler on the overbed table.</p> <p>Observations in Resident #6's room on 4/6/09 at 2:23 PM, revealed Nurse #2 obtained a container of honey consistency water from the cooler on the overbed table and administered medications to Resident #6. The physician's order for nectar thickened liquids was not followed.</p> <p>Observations in Resident #6's room on 4/7/09 at 11:05 AM and on 4/8/09 at 8:05 AM, revealed a container of honey consistency water in the cooler on the overbed table.</p> <p>During an interview in the break room on 4/8/09 at 1:15 PM, the Director of Nursing (DON) stated, "She [Resident #6] should be getting Nectar [thickened liquids]..."</p>	F 309	<p>Resident #6 will be provided the proper consistency of liquids as ordered per MD orders. Therapeutic diet with liquid consistency will be followed for all residents. The Director of Nurse's will in service all nursing staff (RN, LPN &amp; CNA) to monitor liquids per MD orders for desired consistency. Dietary Supervisor and or dietary staff will also monitor diet card to assure MD orders are followed for desired consistency of liquids. The Director of Nurse's of her designee will add the proper MD order for consistency of liquids to the MAR monthly, and the medication nurse will check Q shift and initial this was done. This tag will be monitored Qmonth through the QA committee for compliance until the next survey.</p> <p style="text-align: right;">4-25-09</p>
F 314	483.25(c) PRESSURE SORES	F 314	

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F 314 Continued From page 2  
SS=D

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable, and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:  
Based on policy review, medical record review, observations, and interviews, it was determined the facility failed to provide the necessary treatment and services to promote the healing of pressure sores for 1 of 1 (Resident #3) sampled residents observed during a dressing change.

The findings included:

Review of the facility's "Procedure for Dressing Changes" policy documented "...1. WASH YOUR HANDS, GET THE WOUND CARE CADDY OR YOUR SUPPLIES, AND GO TO THE RESIDENT'S ROOM...5. ARRANGE YOUR SUPPLIES ON THE TOWEL, OPEN PACKAGES, OPEN TUBES OF OINTMENT, TEAR TAPE IF NEEDED... 6. PUT ON GLOVES AND REMOVE OLD DRESSING. PLACE [old dressing] IN RED BAG ALONG WITH YOUR GLOVES. 7. WASH HANDS. PUT CLEAN GLOVES ON AND PROCEED WITH APPLYING DRESSING..."

Medical record review for Resident #3 documented an admission date of 4/30/05 with

F 314

T 314  
Resident #3 will have the necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. The Director of Nurse's will inservice Nursing staff (LPN&RN) on proper procedure and policy for using proper infection control and handwashing techniques, and following specific MD orders to ensure proper wound care to promote healing, decrease opportunity for new sores and contamination of wound. The Director of Nurse's will monitor these procedures on a checklist for proper wound care, proper handwashing technique, following specific MD orders to promote wound healing, decrease the opportunity for new sore, and contamination of the wound. Tag will be monitored by Quality Assurance Committee monthly until next annual survey.

4-25-09

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F 314

Continued From page 3

diagnoses of Diabetes Mellitus, Anemia, Peripheral Vascular Disease, Depression, Syncope, Obesity, and Pressure Ulcer. Review of the physician's order dated 4/3/09 documented "...Apply Bactroban ointment to wound of left heel & [and] then apply sterile dressings and coban twice daily..."

Observations in Resident #3's room on 4/8/09 at 9:30 AM, revealed Resident #3 seated in a wheelchair at the bedside with her left foot elevated on a chair placed in front of her. Nurse #3 placed a towel over the overbed table and placed the dressing supplies on the towel. Nurse #3 then placed a towel over the seat of the chair in front of Resident #3 and positioned Resident #3's left foot on the towel. Nurse #3 squeezed approximately 1 inch of Bactroban ointment onto a Telfa dressing. Nurse #3 then gloved, removed the old dressing from Resident #3's left heel, sprayed Saf Clens wound cleanser onto a 4 by (x) 4 gauze, and wiped across the wound 5 times. Nurse #3 wiped around the wound, all around the heel and bottom of the foot, and back across the wound a total of 14 times without changing areas of the gauze or using different gauze. After washing her hands and regloving, Nurse #3 applied the Telfa with Bactroban onto the wound, and set Resident #3's foot back down onto the towel on the chair. When Nurse #3 was attempting to wrap the heel and dressing with Coban, the Telfa pad fell off of Resident #3's foot onto the towel. Nurse #3 picked up the Telfa pad and held it on Resident #3's heel while she wrapped the heel with Coban.

During an interview at the nurses' station on 4/8/09 at 9:28 AM, Nurse #3 stated "...I don't have an order to clean it [wound], but I'm going to

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F 314 Continued From page 4  
[clean it]..."

F 332 483.25(m)(1) MEDICATION ERRORS  
SS=E  
The facility must ensure that it is free of medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced by:  
Based on review of "Medication Guide for the Long-Term Care Nurse", policy review, medical record review, observation, and interview, it was determined the facility failed to ensure 2 of 3 medication nurses (Nurse #1 and #2) administered medications without a medication error rate of less than 5 percent (%). A total of 3 medication errors were observed out of 42 opportunities for error, resulting in a medication error rate of 7.14%.

The findings included:

1. Review of "Medication Guide for the Long-Term Care Nurse" sixth edition, page 75 documented, "...wait one minute between "puffs" for multiple inhalations of the same drug..."

Medical record review for Resident #11 documented an admission date of 4/15/08 with diagnoses of Myasthenia Gravis, Depression, and Chronic Obstructive Pulmonary Disease. Review of physician orders dated 2/5/09 documented, "...Proair 90 mcg [micrograms] aer [aerosol] 2 puffs twice daily..."

Observations in Resident #11's room on 4/6/09 at 2:20 PM, revealed Nurse #2 handed Resident #11 the Proair. Resident #11 administered 2 puffs

F 314

F 332 F 332  
Resident #1 & 11 will be given their medication as per "Medication Guide for the Long Term Care Nurse" and facility policy and procedure. The facility will assure that Meds will be given as prescribed per MD order. The Director of Nurse's and/or designee will in service all nursing staff individually on proper medication administration (for all meds, P.O., inhalers, or injectable); 5 rights for giving meds, infection control. This check off will be documented. This check off will be done quarterly. Tag will be monitored by Quality Assurance Committee monthly until next annual survey.

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F 332 Continued From page 5  
of the aerosol without waiting any time between the puffs. The administration of Proair aerosol without waiting anytime between puffs resulted in medication error #1.

F 332

Observations in Resident #11's room on 4/7/09 at 8:50 AM, revealed Nurse #1 handed Resident #11 the Proair. Resident #11 administered 2 puffs of the aerosol without waiting any time between the puffs. The administration of Proair aerosol without waiting anytime between puffs resulted in medication error #2.

During an interview at the nurses' station on 4/7/09 at 1:50 PM, Nurse #1 stated, "She [Resident #11] had been doing it for years [self-administering the inhaler]. I guess we can hold it [inhaler] and do it [administer the inhaler] ourselves."

2. Review of the facility's insulin injection policy documented, "...e. Draw up the prescribed amount of insulin..."

Medical record review for Random Resident (RR) #1 documented an admission date of 2/2/06 with diagnoses of Hypertension, Diabetes with Ketoacidosis, Non-Insulin Dependent Diabetes Mellitus, and Psychosis. Review of physician orders dated 2/5/09 documented, "...Lantus 100 u [units] / [per] 1 ml [milliliter] inject 20 units sub-q [subcutaneous] every morning..."

Observations in RR #1's room on 4/7/09 at 9:00 AM, revealed Nurse #1 administered Lantus 25 units. The administration of the incorrect dosage of Lantus resulted in medication error #3.

During an interview at the nurses station on

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<p>F 332</p> <p>F 333 SS=D</p>	<p>Continued From page 6</p> <p>4/7/09 at 1:50 PM, Nurse #1 stated, "I guess I was looking at the 4:00 PM one [dose of insulin]."</p> <p>483.25(m)(2) MEDICATION ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</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 1 of 2 (Random Resident #1) residents observed receiving insulin injections was free of a significant medication error.</p> <p>The findings included:</p> <p>Review of the facility's insulin injection policy documented, "...Draw up the prescribed amount of insulin..."</p> <p>Medical record review for Random Resident (RR) #1 documented an admission date of 2/2/06 with diagnoses of Hypertension, Diabetes with Ketoacidosis, Non-Insulin Dependent Diabetes Mellitus, and Psychosis. Review of physician orders dated 2/5/09 documented, "...Lantus 100 u [units] / [per] 1 ml [milliliter] inject 20 units sub-q [subcutaneous] every morning..."</p> <p>Observations in RR #1's room on 4/7/09 at 9:00 AM, revealed Nurse #1 administered Lantus 25 units. The administration of the incorrect dosage of Lantus resulted in a significant medication error.</p> <p>During an interview at the nurses station on 4/7/09 at 1:50 PM, Nurse #1 stated, "i guess I</p>	<p>F 332</p> <p>F 333</p>	<p>All residents will receive insulin injection as per facility policy and procedure, "Draw up the prescribed amount of insulin." Residents will receive insulin injections as prescribed per MD order. In service will be done per Director of Nurse's on policy and procedure of facility's insulin injection. This will be documented per a check off list per the Director of Nurse's and/or her designee in which the medication nurse will be verbally instructed and observed doing procedure. Inservice will include 5 rights of giving medication and administration and following MD specific order. This tag will be monitored per Quality Assurance Committee monthly until next survey.</p>	<p>4-25-09</p>
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F 333 Continued From page 7  
was looking at the 4:00 PM one [dose of insulin]."

F 441 483.65(a) INFECTION CONTROL  
SS=D  
The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.

This REQUIREMENT is not met as evidenced by:  
Based on policy review, observation and interview, it was determined the facility failed to ensure staff followed infection control practices to prevent the transmission of infection during medication administration for 1 of 1 Random Resident (RR) #1.

The findings included:  
  
Review of the facility's "PREPARATION OF DOSES GENERAL INSTRUCTIONS" policy documented, "...Procedures: ...3. Sanitary techniques will be used in the preparation of any medication. Follow standard Precautions: a. Handwashing will be done immediately prior to preparation for each dose time and whenever the nurse has contact with body secretions (i.e. [for example] eye meds [medications], NGT [nitroglycerin]). Alternatives to handwashing such as isopropyl alcohol gel or foam may be used between residents, and when the nurse has not

F 333  
F441  
F 441 The facility will establish and maintain an infection control program to provide a safe, sanitary, and comfortable environment to prevent the development and transmission of disease and infection. This will be done by using proper handwashing, or using isopropyl alcohol gel or foam between residents. The Director of Nurse's and/or her designee will in service nursing staff on policy and procedure of infection control, medication administration and handwashing technique and or using isopropyl alcohol gel or foam. This will be monitored Q month with documentation and observation of staff. The Director of Nurse's and/or her designee will monitor infection control program under which will investigate, control and prevent infections in the facility. A record of incidents and corrective actions related to said infections will be maintained Q month and monitored per Quality Assurance Committee. Tag will be monitored Q month5 rights of giving medications and document. This review will be done quarterly per the Director of Nurse's and/or her designee. Tag will be monitored by Quality Assurance Committee monthly until next survey. *4-25-09*

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F 441 Continued From page 8  
come in contact with any body secretions" F 441

Observations outside Random Resident (RR) #1 room, during medication administration on 4/7/09 at 9:00 AM, Nurse #1 prepared RR #1's medication. A glove fell on the floor and Nurse #1 picked the glove up from the floor and continued to prepare the medications. Next a pill (Reglan) fell on the floor. Nurse #1 picked the pill up and threw it away and proceeded to open up an insulin syringe and drew up 25 units of insulin. Nurse #1 entered RR #1's room and with gloved hands administered one drop of Fluorometholone in RR #1's right eye. Nurse #1 touched RR #1's lower eyelid with the eye medication dropper. Using the same dropper Nurse #1 administered one drop of eye medication in RR #1's left eye. With the same gloved hands Nurse #1 administered RR #1's insulin in her right upper arm, then administered RR #1's oral medications. Nurse #1 left RR #1's room, went back to the medication cart and dropped a box of gloves on the floor. Nurse #1 picked the box of gloves up and placed them back on the medication cart. Nurse #1 used contaminated gloves, contaminated the eye drop medication dropper and failed to wash her hands throughout this entire process.

During an interview at the nurses' station on 4/7/09 at 1:50 PM, Nurse #1 stated, "Did I not use sanitizer?"

F 444 483.65(b)(3) PREVENTING SPREAD OF INFECTION F 444

The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.

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F 444	Continued From page 9  This REQUIREMENT is not met as evidenced by: Based on policy review, observations, and interview, it was determined the facility failed to ensure 2 of 3 (Nurse #1 and 3) nurses observed washed their hands appropriately and when necessary.  The findings included:  1. Review of the facility's "PREPARATION OF DOSES GENERAL INSTRUCTIONS" policy documented, "...Procedures: ...3. Sanitary techniques will be used in the preparation of any medication. Follow standard Precautions: a. Handwashing will be done immediately prior to preparation for each dose time and whenever the nurse has contact with body secretions (i.e. [for example] eye meds [medications], NGT [nitroglycerin]). Alternatives to handwashing such as isopropyl alcohol gel or foam may be used between residents, and when the nurse has not come in contact with any body secretions"  Observations outside Random Resident (RR) #1's room, during medication administration on 4/7/09 at 9:00 AM, Nurse #1 prepared RR #1's medication. A glove fell on the floor and Nurse #1 picked the glove up from the floor and continued to prepare the medications. Next a pill (Reglan) fell on the floor. Nurse #1 picked the pill up and threw it away and proceeded to open up an insulin syringe and drew up 25 units of insulin. Nurse #1 entered RR #1's room and with gloved hands administered one drop of Fluorometholone in RR #1's right eye. Nurse #1 touched RR #1's lower eyelid with the eye medication dropper	F 444	F444 All residents of facility will receive their medication in a manner in which the nursing staff will prevent the spread of infection. As per facility policy and procedure all staff are required to wash their hands or use isopropal alcohol gel or foam, after contamination of items or between direct contact which handwashing is indicated by accepted professional practice. The Director of Nurse'e and/or her designee will inservice all nursing staff on the policy and procedure of infection control, medication administration, proper handwashing and or use of isopropol alcohol gel or foam. This will be monitored Q month. Tag will be monitored Q month per Quality Assurance Committee until next survey.	4-25-09

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445470</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/08/2009</b>
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F 444	<p>Continued From page 10</p> <p>Using the same dropper Nurse #1 administered one drop of eye medication in RR #1's left eye. With the same gloved hands Nurse #1 administered RR #1's insulin in her right upper arm, then administered RR #1's oral medications. Nurse #1 left RR #1's room, went back to the medication cart and dropped a box of gloves on the floor. Nurse #1 picked the box of gloves up and placed them back on the medication cart. Nurse #1 did not wash her hands throughout this entire process.</p> <p>During an interview at the nurses' station on 4/7/09 at 1:50 PM, Nurse #1 stated, "Did I not use sanitizer?"</p> <p>2. Review of the facility's "Handwashing" policy documented "...5. Dry hands with paper towel 6. Turn off faucet with paper towel..."</p> <p>Observations in Resident #3's room on 4/8/09 at 9:30 AM, revealed Resident #3 seated in a wheelchair at the bedside with her left foot elevated on a chair placed in front of her. Nurse #3 went into the hallway bathroom, washed her hands, turned off the faucet with her bare hand, and then dried her hands with a paper towel</p>	F 444		