

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

PRINTED: 06/15/2010
FORM APPROVED
OMB NO. 0938-0391

JUL 02 2010

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 06/09/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER ARBOR PLACE OF PURYEAR	STREET ADDRESS, CITY, STATE, ZIP CODE 220 W CHESTNUT, PO BOX 306 PURYEAR, TN 38251
--	--

(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 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 review of the "TENNESSEE CNA [Certified Nursing Assistant] Candidate Handbook," review of the facility's resident bill of rights, medical record review and observations, it was determined the facility failed to ensure that full visual privacy was provided during suprapubic</p>	F 164	<p>Residents #6 and 9 will have privacy and respect and be treated with consideration, respect and full recognition of their dignity and individually including privacy in treatment and in care for their personal needs. All staff will be in-serviced by the DON and or the Administrator 6-25-2010 on resident's rights: the right to have personal privacy and confidentiality of his or her personal and clinical records. That 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. 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>	6-25-2010
---------------	---	-------	---	-----------

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Joanne Newbill Administrator

DATE
revised
 6/30/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may not have sufficient protection to the patients. (See instructions.) Except for nursing homes, the date of survey whether or not a plan of correction is provided. For nursing homes, the date of survey whether or not a plan of correction is provided. For nursing homes, the date of survey whether or not a plan of correction is provided. For nursing homes, the date of survey whether or not a plan of correction is provided.

terminated that
 table 90 days
 disclosure 14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 06/15/2010
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 06/09/2010
NAME OF PROVIDER OR SUPPLIER ARBOR PLACE OF PURYEAR			STREET ADDRESS, CITY, STATE, ZIP CODE 220 W CHESTNUT, PO BOX 306 PURYEAR, TN 38251		
(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 164	<p>Continued From page 1</p> <p>catheter care and medication administration of Insulin for 2 of 14 (Residents #6 and 9) sampled residents.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Review of the "TENNESSEE CNA Handbook, Version 4.0, OCT [October] 1, 2009" page 10 documented, "Skill 7-Catheter Care ...4. Provides for resident's privacy pulls privacy curtain." Review of the facility's resident bill of rights documented, "...9. Privacy and respect.. You shall be treated with consideration, respect, and full recognition of your dignity and individually, including privacy in treatment and in care for your personal needs." Medical record review for Resident #6 documented an admission date of 4/30/10 with a diagnoses of Alzheimer, Dementia, Acute Renal Failure, Hypertension and Supra Pubic Catheter. <p>Observation in Resident #6's room on 6/8/10 at 2:20 PM, revealed Nurse #1 failed to pull the curtain or close the door during Resident #6's suprapubic catheter care.</p> <ol style="list-style-type: none"> Medical record review for Resident #9 documented an admission date of 5/8/10 and a readmission date of 5/20/10 with diagnoses of Obesity, Urinary Tract Infection, Venous Insufficiency, Amputation of 2 toes right foot, Psychosis, and Intravenous Antibiotic Therapy. <p>Observations in Resident #9's room on 6/8/10 at 11:30 AM, Nurse #1 administered Insulin subcutaneously into Resident #9's left arm. Nurse #1 failed to close the door or completely close the</p>	F 164	<p>All residents will be provided privacy for all personal care and/or procedures by staff as evident that staff will close the door completely and/or pull the privacy curtain completely. The DON and/or her designee will make monthly rounds and record their findings for compliance, (the date and results). If staff member is found not to be in compliance immediate in-service and written reprimand will be given. The tag will be monitored by Quality Assurance Committee monthly until next survey.</p>		

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

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 06/09/2010
NAME OF PROVIDER OR SUPPLIER ARBOR PLACE OF PURYEAR			STREET ADDRESS, CITY, STATE, ZIP CODE 220 W CHESTNUT, PO BOX 306 PURYEAR, TN 38251	
(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 164 F 174 SS=D	Continued From page 2 privacy curtain to provide privacy for Resident #9. 483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. This REQUIREMENT is not met as evidenced by: Based on the group interview and a staff member interview, it was determined the facility failed to provide telephone access where conversations could not be overheard or interrupted for 3 of 7 alert and oriented residents attending the group meeting. The findings included: The group interview was conducted in Room 107 on 6/8/10 at 10:30 AM, with 7 residents that the facility had identified as being alert and oriented. Three (3) of the 7 alert and oriented residents stated that they use the phone at the nurses' station to make phone calls. The three resident's felt that their conversations were not private and that sometimes their conversation was interrupted by the fax machine. During an interview in the conference room on 6/9/10 at 8:10 AM, the Social Worker/Activity Director confirmed that the phone the resident's used at the nurses' station was hooked up to a fax machine. The phone that the resident's would be using was hooked up to the pharmacy's fax and that the fax was hardly ever used.	F 164 F 174	The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. A new cordless phone was purchased for the resident's use. This phone will reach the resident's rooms for a private conversation. If needed, a private area will be provided at the resident's request. The facility has acquired a separate phone line. This project is finished 6-22-2010	6/16/2010 6/22/2010
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT	F 225		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 08/15/2010
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 06/09/2010
NAME OF PROVIDER OR SUPPLIER ARBOR PLACE OF PURYEAR			STREET ADDRESS, CITY, STATE, ZIP CODE 220 W CHESTNUT, PO BOX 308 PURYEAR, TN 38251		
(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 3</p> <p>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 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> <p>This REQUIREMENT is not met as evidenced</p>	F 225	<p>The DON will report all allegations of mistreatment, neglect or abuse including injuries of an unknown source and misappropriation of resident property to the administrator or his/her designated representative and to other officials in accordance with State law (including to the State survey/certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action will be taken.</p> <p>This information given by the State survey team was printed and also given to the Corporate Clinical Consultant. In-service will be given to all staff by the DON and or Administrator on 6/25/2010 to review Abuse policy with all staff. This tag will be monitored by the Quality Assurance Committee monthly until the next survey.</p>	6/9/2010	

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

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 06/09/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER ARBOR PLACE OF PURYEAR	STREET ADDRESS, CITY, STATE, ZIP CODE 220 W CHESTNUT, PO BOX 306 PURYEAR, TN 38251
--	--

(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 4</p> <p>by: Based on review of employee personnel files and interviews, it was determined the facility failed to report an alleged allegation of verbal abuse to the state survey and certification agency for 1 of 3 Certified Nurses Assistant (CNA #2) employee personnel files reviewed.</p> <p>The findings included:</p> <p>Review of the personnel file for CNA #2 documented an alleged occurrence of verbal abuse on 11/18/09 that was not reported to the state.</p> <p>During an interview in the conference room on 6/9/10 at 12:50 PM, the Director of Nurses (DON) confirmed that she had not reported the alleged allegation of verbal abuse. The DON stated she had talked to the corporate nurse and was informed that the verbal abuse did not have to be reported.</p>	F 225		
F 323 SS=D	<p>483.26(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to monitor hot water temperatures in 1 of 3 (Mens bathroom across</p>	F 323	<p>The facility will ensure that the resident environment will remain as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>The men's restroom plumbing was re-routed to another water heater that reduced the temp. to a normal reading. Tag will be monitored by QA</p>	6/8/2010

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

 PRINTED: 06/15/2010
 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 06/09/2010
NAME OF PROVIDER OR SUPPLIER ARBOR PLACE OF PURYEAR			STREET ADDRESS, CITY, STATE, ZIP CODE 220 W CHESTNUT, PO BOX 306 PURYEAR, TN 38251		
(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 (from the conference room) common areas and ensure proper storage of germicidal wipes in 1 of 17 (Random Resident #4's room) resident rooms.</p> <p>The findings included:</p> <p>1. Observation in the mens bathroom across from the conference room on 6/7/10 at 10:13 AM, revealed the hot water temperature in the sink registered 126 degrees Fahrenheit (F).</p> <p>Observations in the mens bathroom across from the conference room on 6/7/10 at 2:25 PM, revealed the Maintenance Manager checked the hot water temperature with the facility's thermometer along with the surveyor present. The hot water temperature registered 138 and 140 degrees F. The facility took immediate action to correct the problem when it was brought to their attention. There are no male residents that use this common men's bathroom.</p> <p>During an interview in the main hallway on 6/7/10 at 2:25 PM, the Maintenance Manager stated, "I've not checked this sink [in the mens common use bathroom] since we've been here..."</p> <p>2. Observations In Random Resident (RR) #4's room on 6/7/10 at 9:40 AM and 1:25 PM, revealed a container of Sani-Cloth Germicidal disposable wipes on top of RR #4's television. The back of the container stated, "Keep out of reach of children."</p> <p>During an interview in RR #4's room on 6/7/10 at 1:25 PM, Nurse #1 confirmed that the wipes had been used at the time RR #4 received wound care.</p>	F 323	<p>Committee monthly until next survey.</p> <p>Sani Cloth Germicidal disposable wipes on top of RR#4 were removed by Nurse#1. The policy regarding the storage of Sani-Cloth Germicidal disposable wipes was revised, by the Administrator 6/10/2010. These wipes will be stored in the Nurse's Med room and will not be permitted to be left in other areas of resident care, or left unsupervised. In-service will</p>	6/25/2010	

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

PRINTED: 06/15/2010
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 _____ D. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ARBOR PLACE OF PURYEAR	STREET ADDRESS, CITY, STATE, ZIP CODE 220 W CHESTNUT, PO BOX 300 PURYEAR, TN 38251
---	--

(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 During an interview in the conference room on 6/9/10 at 11:00 AM, the Director of Nurses (DON) was asked if the germicidal wipes were to be kept in RR #4's room. The DON stated, "No. The wipes should be kept in the medication room."	F 323		6/25/2010
F 431 SS=D	<p>483.80(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1978 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>	F 431 F431	<p>be given by the DON and or Administrator to all Nurses. Staff will sign sheet for validation. The DON or her designee will review policy quarterly with staff and document. Tag will be monitored by the Quality Assurance Committee monthly until next survey.</p> <p>The Nursing Staff will be in-serviced by the DON and or Administrator on the policy regarding Storage of Medications 6/25/2010. This Policy and Procedure includes who has access to the Medication supply; it is only assessable only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. The Med room door, refrigerator, cabinets and carts will be locked when unattended by an authorized person. This will be monitored daily by the DON and/or her designee and documented for compliance.</p> <p>Nurse#2 was given a written reprimand, 6/15/2010. Future infractions will require disciplinary action and/or termination.</p>	6/25/2010 6/15/2010

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 06/15/2010
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 06/09/2010
NAME OF PROVIDER OR SUPPLIER ARBOR PLACE OF PURYEAR			STREET ADDRESS, CITY, STATE, ZIP CODE 220 W CHESTNUT, PO BOX 306 PURYEAR, TN 38251	
(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 431	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure medications were stored in locked storage areas at all times for 1 of 4 (medication storage room) medication storage areas. The findings included: Review of the facility's medication storage policy documented, "... The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications... 3... Medication rooms, cabinets and medication supplies are locked or attended by persons with authorized access..." Observations in the Nurses' Station on 6/8/10 at 6:00 AM, revealed the medication storage room door was propped open and left unattended. Nurse #2 was on the 100 hall with the medication cart giving medications. The medication storage room was not in full view of Nurse #2 at all times. During an interview in the Nurses' Station on 6/8/10 at 6:05 AM, Nurse #2 was asked, "Is the medication room supposed to be locked all the time?" Nurse #2 stated, "Yes."	F 431	Tag will ne monitored by Quality Assurance Committee until next survey.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441	Resident#6and #9 the staff will use the established Infection Control Program to help prevent the development and transmission of disease and infection.	6/15/2010

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

PRINTED: 06/15/2010
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 06/09/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER ARBOR PLACE OF PURYEAR	STREET ADDRESS, CITY, STATE, ZIP CODE 220 W CHESTNUT, PO BOX 306 PURYEAR, TN 38251
--	--

(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 8 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 transport linens so as to prevent the spread of infection.</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 2 of 4 (Nurses #1 and 4)</p>	F 441	<p>The facility will maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of disease and infection.</p> <p>Nurses #1&4 and CNA #1 will have one on one in-service instructions on 6/25/2010 on policies listed below, given by DON.</p> <p>In-service to all staff will be given by DON and/or Administrator on 6/25/2010 policy for Handwashing, Infection Control. Cleaning of soiled Equipment, Use and Storage of Sani- Cloth Wipes. Dining Room Service, Use of Glucometer and Sanitation, Sanitation of Flex Pen, Contact Isolation.</p> <p>The DON and /or her designee will monitor staff for compliance of these policies and document at least quarterly. Tag will be monitored by the Quality Assurance Committee monthly until next survey.</p>	6/25/2010

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 06/15/2010
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 06/09/2010
NAME OF PROVIDER OR SUPPLIER ARBOR PLACE OF PURYEAR			STREET ADDRESS, CITY, STATE, ZIP CODE 220 W CHESTNUT, PO BOX 306 PURYEAR, TN 38261		
(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)	(X3) COMPLETION DATE	
F 441	<p>Continued From page 9</p> <p>nurses maintained proper infection control practices during a dressing change and catheter care; use of a glucometer and Flex Pen and/or handwashing. One (1) of 3 Certified Nursing Assistants (CNA #1) failed to wash her hands when indicated during dining observations.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility's "General Infection Control" policy documented, "...4. Emphasis shall be placed on proper / appropriate handwashing techniques as significant factor in preventing infections and diseases from spreading... Infection Control ...2. Personal hygiene and proper hand care shall be stressed. 3. Wash hands before and after patient care, before handling clean equipment and supplies, and after handling anything soiled/contaminated, after using bathroom, before serving food... 6...Contaminated equipment shall be washed with disinfectant... 9. Nursing Procedures: All procedures shall reflect infection control measures and techniques. Besides use of sterile supplies and equipment, the manner in which care and treatments are given must also be antiseptic." 2. Review of the facility's "Cleaning and Disinfecting the Microdot Blood Glucose Meter" policy documented, "It is [name of medical product] policy to advise healthcare professionals to clean and disinfect blood glucose meters between each resident test in order to avoid cross - contamination issues... The following Germicidal products are also acceptable disinfectants for use on meters: Super Sani -Cloth Germicidal Wipe ... Sani Cloth Germicidal Disposable Wipe..." 	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 06/15/2010
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 06/09/2010
NAME OF PROVIDER OR SUPPLIER ARBOR PLACE OF PURYEAR			STREET ADDRESS, CITY, STATE, ZIP CODE 220 W CHESTNUT, PO BOX 306 PURYEAR, TN 38261		
(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 10</p> <p>3. Observations in Resident #9's room on 6/8/10 at 11:30 AM, revealed Nurse #1 placed the glucometer and other supplies on Resident #9's bedside table without cleaning or using a barrier. Nurse #1 completed the sampling of Resident #9's blood with the glucometer and without cleaning the glucometer. Nurse #1 returned the glucometer back on the working surface of the medication cart located outside of Resident #9's room. Nurse #1 proceeded to wipe the contaminated glucometer with an alcohol pad and place the wet glucometer into the top right draw of the medication cart.</p> <p>4. Observations in Random Resident #3's room on 6/8/10 at 11:37 AM, Nurse #1 failed to clean the insulin Flex Pen prior to administering insulin, then placed the Flex Pen on top of the medication cart. Nurse #1 placed the contaminated Flex Pen in a container with other vials of insulin failing to clean the Flex Pen then returned the container in a draw of the medication cart.</p> <p>During an interview in the conference room on 6/9/10 at 3:46 PM, the Director of Nurses confirmed that, the cleaning and disinfection of the blood glucose meter, Flex Pen and other equipment used for residents and between residents are to be cleaned and disinfected per facility protocol/policy.</p> <p>5. Review of the facility's "CONTACT ISOLATION" policy documented, "Contact Isolation is used for residents with a diagnosis of an infection that requires separation of clothing, linen, and or any utensils or dressing that may come in contact with the source of infection... Linens will be placed in a specified hamper in the resident's room."</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 06/15/2010
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 06/09/2010
NAME OF PROVIDER OR SUPPLIER ARBOR PLACE OF PURYEAR			STREET ADDRESS, CITY, STATE, ZIP CODE 220 W CHESTNUT, PO BOX 306 PURYEAR, TN 38261		
(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 11 Medical record review for Resident #6 documented an admission date of 4/30/10 with a diagnoses of Alzheimer, Dementia, Acute Renal Failure, Hypertension and Supra Pubic Catheter. Review of the Physician's Interim/Telephone Order dated 5/26/10 documented, "Drainage from supra pubic catheter cultured-returned MRSA [Methicillin Resistant Staphylococcal Aureus] -Septra DS 1 Bid [twice a day] po [by mouth] x [times] 14 days. Contact Isolation." Observations in Resident #6 room on 6/8/10 at 2:20 PM, revealed Nurse #1 cleaned around Resident #6's supra pubic catheter. When Nurse #1 gathered the supplies, she placed the gloves in her uniform pocket. Nurse #1 obtained washcloths and laid them in the bottom of the sink to wet them. Nurse #1 then washed around Resident #6's supra pubic area and placed the soiled wet washcloths on Resident #6's bedspread at the foot of the bed without a barrier. After the catheter care was done Nurse #1 put the gown she had on and the washcloths in the regular clothes hamper in the hallway instead of in an isolation container. Observations in Resident #6 room on 6/8/10 at 2:40 PM, revealed Nurse #1 did a dressing change on Resident #6's lower right buttocks. After the DuoDerm was applied Nurse #1 took the supplies out of the room and placed the box of gloves on top of the treatment cart. 6. Observations in RR #1's room on 6/9/10 at 10:20 AM, Nurse #1 removed RR #1's socks and Band-Aid dressing from RR #1's right foot. Nurse #1 disposed of the Band-Aid and removed her gloves. Nurse #1 regloved and cleansed the	F 441	Resident #6, #5, and #1 will be cared for by using established Policies and Procedures for Infection Control, Contact Isolation, and dressing/wound care technique; to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Nursing staff will be in-serviced by DON and/ or Administrator on 6/25/2010 Infection Control, Contact Isolation technique and Dressing Change/Wound Care technique. A check off sheet will be used monthly for documentation of proficiency of these skills by the DON and/or her designee. Tag will be monitored by Quality Assurance Committee monthly until next survey.	6/25/2010	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 06/15/2010
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 06/09/2010
NAME OF PROVIDER OR SUPPLIER ARDOR PLACE OF PURYEAR			STREET ADDRESS, CITY, STATE, ZIP CODE 220 W CHESTNUT, PO BOX 306 PURYEAR, TN 38251		
(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 12 wounds with wound cleanser and gauze. Nurse #1 disposed of the used gauze. Nurse #1 then applied triple antibiotic ointment to her gloved finger and applied the ointment to the wound without changing her gloves. 7. Observations in the main dining room on 6/7/10 at 5:20 PM, 5:25 PM and 5:30 PM, revealed CNA #1 washed her hands and then turned the faucet off with her bare hands Observations in the dining room on 6/7/10 at 5:24 PM, CNA #1 picked up the head cushion from a resident's gerichair that had fallen on the floor, then sat down at the table, and preceded to assist another resident to eat without washing her hands. 8. Observation in the main dining room on 6/7/10 at 5:30 PM, revealed Nurse #4 washed her hands, touched the trash can with her bare hand after throwing away the paper towel and proceeded to get mayonnaise for Resident #5. 9. Observations in the dining room on 6/8/10 at 7:43 AM and 7:45 AM, revealed Nurse #1 positioned a resident in her wheelchair, positioned the resident's wheelchair at the table and proceeded to assist another resident with eating without washing her hands.	F 441			