

RECEIVED
 SEP 26 2011
 FORM APPROVED
 OMB NO. 0938-0391
 DATE SURVEY COMPLETED
 09/08/2011

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 09/08/2011
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NAME OF PROVIDER OR SUPPLIER ARBOR PLACE OF PURYEAR INC	STREET ADDRESS, CITY, STATE, ZIP CODE 220 COLLEGE STREET PURYEAR, TN 38251
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(24) 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)	(25) COMPLETION DATE
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F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY
 SS=D

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:
 Based on observation and interview, it was determined the facility failed to ensure 1 of 3 (Nurse #2) nurses knocked on the door or gained permission prior to entering the residents room during medication administration.

The findings included:
 Observations on hall 1 on 9/6/11 at 11:23 AM, Nurse #2 entered resident room 112 without knocking or gaining permission to enter.
 Observations on hall 2 on 9/6/11 at 12:05 PM, Nurse #2 entered resident room 168 without knocking or gaining permission to enter.
 During an interview in the Director of Nursing's (DON) office on 9/8/11 at 1:58 PM, the DON confirmed the staff should knock on the door before entering a resident's room.

F 241

This facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The residents in room #112, #168, and all residents will be treated in this manner. All staff will knock on the door or gain permission prior to entering the resident's room during medication administration.
 All staff will be in-serviced by the DON 9-10-2011: This will be monitored monthly by the DON or her designee. This tag will be monitored per Quality Assurance committee monthly for compliance until next survey.

9-10-2011

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP
 SS=D

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.

F 280

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Joanna Newbuhl 9/23/11</i>	TITLE	(X6) DATE
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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.

This same doc was fax 9/23/11

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NAME OF PROVIDER OR SUPPLIER ARBOR PLACE OF PURYEAR INC		STREET ADDRESS, CITY, STATE, ZIP CODE 220 COLLEGE STREET 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 200 Continued From page 1

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 medical record review, observation and interview, it was determined the facility failed to revise the comprehensive care plan to reflect the use of a gerichair for 1 of 9 (Resident #4) sampled residents.

The findings included:

Medical record review for Resident #4 documented an admission date of 8/30/04 with diagnoses of Paranoid Schizophrenia, Macular Degeneration, Cardiovascular Disease, Congestive Heart Failure and Aortic Stenosis. Review of the comprehensive care plan dated 8/30/11 documented, "...Problem... Potential for injury/falls related to decreased mobility and low endurance... Approach... Wheelchair with foot pedals..." The care plan was not revised to reflect the resident's use of a gerichair instead of a

F 200.

All residents have 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 will be developed within 7 days after the completion of the comprehensive assessment; prepared by the interdisciplinary team, that includes the attending physician, a RN 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.

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F 280 Continued From page 2
 wheelchair when out of bed.

Observations in the dining room on 9/6/11 at 12:00 PM and 4:45 PM, revealed Resident #4 seated in a gerichair at the dining table.

Observations in Resident #4's room on 9/7/11 at 8:15 AM, revealed Resident #4 reclined in a gerichair in the television (TV) room.

Observations in Resident #4's room on 9/7/11 at 10:40 AM, revealed Resident #4 asleep in a reclined gerichair.

During an interview in hall 1 on 9/7/11 at 10:50 AM, Nurse #1 was asked if Resident #4 used a wheelchair when out of bed. Nurse #1 stated, "She [Resident #4] used to sit in a wheelchair all the time, but she hasn't been able to do that for a while now because of her leaning. She uses a gerichair now."

F 314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES
 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 medical record review, observation

F 280:

Resident #4 was sited: The use of a gerichair was not included in this resident's plan of care. Upon review of Resident #4 chart by DON and Administrator it was found that on 6-11-2011 an order was written "May use geri-chair". It was care planned on 6-11-2011, under Falls: "May use geri-chair." This Tag will be sent in for an IDR. This tag will be monitored by Quality Assurance Committee monthly until next Survey.

This tag will be sent in for IDR

F 314:

All residents will have treatment/services to prevent/heal pressure sores. The facility will ensure that a resident who enters the facility without pressure sores do 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.

9-25-2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445470	(C2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(K3) DATE SURVEY COMPLETED 09/08/2011
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F 314 Continued From page 3

and interview, it was determined the facility failed to provide necessary treatment and services to promote the healing of pressure sores for 1 of 1 (Resident #1) sampled residents and failed to obtain a physician's order for a pressure sore treatment for 1 of 1 Random Resident (RR #1) with a pressure sore.

The findings included:

1. Medical record review for Resident #1 documented an admission date of 3/10/11 with a readmission date of 8/12/11 with diagnoses of Aspiration Pnaumonia, Diabetes Mellitus, Vascular Dementia, Cerebrovascular Accident, Anxiety, Depression, Hypoglycemia and Shingles. Review of the "SKIN CONDITION REPORT" dated 9/1/11 documented, "...[symbol for right] Heel... 9/1/11... SIZE (Length, Width, Depth) in cm [centimeters] ...2 cm. X [by] 2 cm... APPEARANCE... [symbol for increase] in size... yellow wound base... [symbol for increase] in depth 0.2 cm..." Review of the physician's orders dated 8/12/11 documented, "...Air Floatation mattress..." Review of the care plan dated 8/19/11 documented, "...Potential for skin breakdown and skin injuries related to decreased mobility (resident requires assistance with transfers) and bowel/bladder incontinence... heel protectors./Heelbo [heel boot]... Air flotation mattress on bed..." Review of the "NURSING ASSISTANT CARE CARD" dated 8/12/11 documented, "...Air Floatation Mattress... Heelbo to [symbol for right] foot..."

Observations in Resident #1's room on 9/6/11 at 10:20 AM, on 9/7/11 at 7:55 AM and on 9/8/11 at 8:15 AM, revealed Resident #1 lying in bed with

F 314-

This facility will provide necessary treatment and services to promote the healing of pressure sores by receiving physician orders for treatment and following those physician orders for treatment. Resident #1 will wear heel bo protectors as ordered. Air mattress will be inflated to decrease pressure areas to body. Said air mattress was replaced due to a malfunction, 9-8-2011. Nursing staff will be in-serviced to observe resident at different intervals of the day to be sure all physician orders are being followed. Staff will observe air mattress several times during the day to be sure it is functioning properly or report to maintenance that is it not functioning properly. This will be checked by the charge nurse and will be charted on daily by the Nursing Assistant Care Card. The Nursing staff will observe resident at intervals to be sure the heel-bo protectors are in use to decrease pressure to the heels.

9-25
2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 314 Continued From page 4
heel boots not on.

Observations in Resident #1's room on 9/8/11 at 10:20 AM and 12:05 PM and on 9/7/11 at 7:55 AM and 2:20 PM, revealed both tubes from the Invacare Pressure Pump System were disconnected from the air mattress which resulted in the mattress being deflated.

Observations in Resident #1's room on 9/8/11 at 8:15 AM, revealed that the air mattress was not under the heels of Resident #1 to relieve pressure from the open area on Resident #1's right heel.

During an interview in Resident #1's room on 9/7/11, the Director of Nursing (DON) was asked about Resident #1's air mattress. The DON stated, "...it's on but no air..."

During an interview in Resident #1's room on 9/8/11, Nurse #1 was asked about the air mattress not being under Resident #1's heels. Nurse #1 stated, "...it's [air mattress] supposed to cover the whole bed..."

During an interview in hall 2 on 9/8/11 at 2:22 PM, the DON was asked why the air mattress and heel protectors were ordered for Resident #1. The DON stated, "...for spots [open areas] on right foot..."

2. Medical record review for RR #1 documented an admission date of 2/17/10 with diagnoses of Dementia, Depression, Vascular Disease, Psychosis and Atherama. Review of the current physician's orders dated 8/25/11 documented, "...TREATMENTS BILATERAL HEELS: APPLY

F 314

This will be documented on the TAR sheet by the Charge nurse and be documented on the Nursing Assistant Care Card. This tag will be monitored by the Quality Assurance Committee monthly until next survey.

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F 314 - Continued From page 5
 HEELBO'S WHILE IN BED APPLY BARRIER CREAM TO AFFECTED AREAS EVERY SHIFT AS NEEDED..." There was no current order for a wound treatment for the pressure ulcer on the sacral area.

Observations in RR #1's room on 9/7/11 at 11:40 AM, revealed RR #1 in bed. Nurse #1 removed a duoderm dressing from the sacral area of RR #1, cleaned the wound with wound cleaner, and applied a new duoderm dressing. Nurse #1 did not have a current order for the treatment of the sacral wound.

During an interview in the chart room on 9/7/11 at 12:00 PM, Nurse #1 was asked if there was a current order for the wound treatment and dressing change. Nurse #1 reviewed the current physician's orders and stated, "I don't know why it's [order] not on there under treatments. It should be. I guess [named nurse] didn't carry it over."

F 323 483.25(h) FREE OF ACCIDENT
 SS-D HAZARDS/SUPERVISION/DEVICES

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.

This REQUIREMENT is not met as evidenced by:
 Based on policy review, medical record review, observation and interview, it was determined the

F 314

All resident's charts will be monitored by the DON and or her designee; there will be a current order for a wound treatment for every resident as needed. RR#1 a Physician clarification order was written for wound care to the sacrum. The order will be transposed onto the current TAR. Nursing staff will be in-serviced that all treatments that should be continued are brought over on the monthly Physician Order Sheet and TAR, if they are not check to see if they are DC'd per Physician's order. The DON and or her designee will in-service nursing staff on this requirement. Charts and POS will be checked by DON and/or her designee monthly for treatment orders to be brought forth on new POS and TAR for the month. This tag will be monitored by the Quality Assurance Committee until next survey.

9-25-2011

F 323

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F 323 Continued From page 6
 facility failed to ensure that a physician's order for arm protectors was followed for a resident at risk for skin injuries or that new interventions were implemented after a fall and that a care plan for falls was followed for residents at risk for falls for 3 of 10 (Residents #1, 2 and 9) sampled residents observed.

The findings included:

1. Medical record review for Resident #1 documented an admission date of 3/10/11 with a readmission date of 8/12/11 with diagnoses of Aspiration Pneumonia, Diabetes Mellitus, Vascular Dementia, Cerebrovascular Accident, Anxiety, Depression, Hypoglycemia and Shingles. Review of the physician's orders dated 8/12/11 documented, "...Arm protectors..." Review of the care plan dated 8/19/11 documented, "...Potential for skin breakdown and skin injuries... May wear arm protectors to both arms..." Review of the "NURSING ASSISTANT CARE CARD" dated 8/12/11 documented, "...Arm protectors..."

Observations in Resident #1's room on 9/6/11 at 10:20 AM and 12:05 PM, on 9/7/11 at 7:55 AM and on 9/8/11 at 8:15 AM, revealed Resident #1 not wearing arm protectors.

Observations in the television (TV) room on 9/8/11 at 11:30 AM, revealed Resident #1 seated in a wheelchair not wearing arm protectors.

Observations in hall 2 on 9/8/11 at 2:22 PM, revealed Resident #1 seated in a wheelchair not wearing arm protectors.

During an interview in hall 2 on 9/8/11 at 2:22 PM,

F 323

The facility will ensure that the resident's environment will remain as free of accident hazards as possible; and each resident receives adequate supervision and assistant devices to prevent accidents. Resident #1 Will wear arm protectors as the physician has ordered, to prevent skin injuries to arms. This will be added to the nurses TAR, it will be monitored daily and Q shift by the Charge Nurse and the DON and or her designee for compliance. Intervention will be added to the Nursing Assistant Care Card. This will be monitored by the Charge Nurse and the DON or her designee for compliance. In-service will be given per the DON and or her designee. This tag will be monitored by the Quality Assurance Committee until the next survey.

9-25
2011

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F 323 Continued From page 7

the Director of Nursing (DON) confirmed Resident #1 was not wearing arm protectors as ordered.

2. Review of the facility's "FALL PREVENTION PROGRAM" policy documented, "...There are many interventions that staff can use to prevent falls and to provide a safe environment for the residents. GOAL: To prevent falls and injury to residents of our facility... The resident's care plan will include a fall problem with interventions to assist the staff in caring for the resident and in preventing falls."

a. Medical record review for Resident #2 documented an admission date of 6/16/11 with a readmission date of 8/19/11 with diagnoses of Pneumonia, End Stage Congestive Heart Failure, Diabetes Mellitus, Hypertension, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease and Asthma. Review of the "FALL RISK ASSESSMENT" dated 8/19/11 documented, "...History of falls... Transfers: Resident requires assistance to transfer safely... Ambulation: Resident requires assistance to ambulate with (circled) or without assistive device... walker... Gait and balance: Resident is unable to maintain balance while sitting, standing or walking without assistance..." Review of the care plan dated 6/22/11 documented, "...Potential for injury/falls related to decreased mobility and low endurance (resident with history of falls prior to admission)..." Review of the nurses' notes dated 7/31/11 documented, "...[staff] heard [name of Resident #2] yell help. [Staff] went to his room [symbol for and] found him [Resident #2] laying beside his bed. His [Resident #2] left side of fore head was bleeding. He stated he rolled off the bed [symbol

F 323

As facility's "Fall Prevention Program" policy is documented, "...There are many interventions that staff can use to prevent falls and to provide a safe environment for the residents. Goal: To prevent falls and injury to residents of our facility... The resident's care plan will include a fall problem with interventions to assist the staff in caring for the resident in preventing falls and or injuries. Resident #2: All falls will have a care plan intervention to prevent fall and or injuries; these interventions shall be put into place by the nursing staff. These interventions will be placed on the TARs to be monitored daily and Q shift by the Charge nurse and added to the Nursing Assistant Care Card. The DON and/or her designee will monitor for compliance. These interventions will be Physician orders that will be on the monthly POS and be transposed on the TARs. The DON and or her designee will monitor for compliance monthly. The DON and or designee will in-service staff on this procedure. The Quality Assurance Committee will monitor this tag for compliance monthly until next survey.

9-25
2011

F 323 Continued From page 8

for and] hit his head on his table..." Review of a care plan revision for falls dated 7/31/11 documented no new interventions after the fall on 7/31/11.

During an interview in the conference room on 9/8/11 at 2:30 PM, the DON confirmed there were no new interventions implemented for Resident #2 after the fall on 7/31/11.

b. Medical record review for Resident #9 documented an admission date of 11/29/10 with a readmission date of 12/28/10 with diagnoses of Senile Dementia, Psychosis, Dehydration and Depression. Review of the "FALL RISK ASSESSMENT" dated 1/10/11 documented, "...TOTAL SCORE... Total score of 10 or above represents HIGH RISK... 16..." Review of the care plan dated 1/5/11 and revised on 8/29/11 documented, "...Potential for injury/falls related to decreased [decreased] mobility and low endurance (resident with history of falls and hip fracture prior to admission to facility... Blue mat on floor at bedside..." Review of the "NURSING ASSISTANT CARE CARD" dated 6/24/11 documented, "...SAFETY... Fall Risk... Blue Mat Next to bed..."

Observations in Resident #9's room on 8/7/11 at 2:30 PM and on 9/8/11 at 9:10 AM and 2:30 PM, revealed no blue mat in Resident #9's room.

During an interview in Resident #9's room on 9/8/11 at 2:30 PM, the DON confirmed there was no blue mat in the room.

F 333 483.25(m)(2) RESIDENTS FREE OF SS=D SIGNIFICANT MED ERRORS

F 323

As facility's "Fall Prevention Program" policy is documented, "...There are many interventions that staff can use to prevent falls and to provide a safe environment for the residents. Goal: To prevent falls and injury to residents of our facility... The resident's care plan will include a fall problem with interventions to assist the staff in caring for the resident in preventing falls and or injuries.

Resident #9: All careplan interventions will be put onto the TARs to be monitored daily and Q shift by the Charge nurse, they will be added onto the Nursing Assistant Care Card to be monitored daily and Q shift. The DON and/or her designee will monitor for compliance. The monthly Physician's Order Sheet will be checked by the DON and or her designee to be sure that each intervention is brought onto the next month's POS and TAR sheet unless it has been discontinued. All nursing staff will be in-serviced on procedure. This tag will be monitored by the Quality Assurance Committee monthly until next survey.

9-25
2011

F 333

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 333 Continued From page 9
 The facility must ensure that residents are free of any significant medication errors.

This REQUIREMENT is not met as evidenced by:
 Based on review of the "MED-PASS COMMON INSULINS" provided by the American Society of Consultant Pharmacists, medical record review, observation and interview, it was determined the facility failed to ensure that residents were free of significant medication errors when 1 of 3 (Nurse #2) nurses failed to administer insulin according to a physician's order and failed to administer insulin within the proper time frame before meals.

The findings included:

1. Review of the "MED-PASS COMMON INSULINS: Pharmacokinetics, Compatibility and Properties" provided by the American Society of Consultant Pharmacists for typical dosing administration of insulin relation to meals documented, "...NOVOLIN R [regular] ...ONSET (In hours, Unless Noted... 0.5- [to] 1 (hours)... 30 minutes before meals..."
2. Medical record review for Resident #1 documented an admission date of 3/10/11 with a readmission date of 8/12/11 with diagnoses of Aspiration Pneumonia, Diabetes Mellitus, Vascular Dementia, Cerebrovascular Accident, Anxiety, Depression, Hypoglycemia and Shingles. Review of the physician's orders dated 8/12/11 documented, "...Accu [symbol for check mark] q [every] 8 [symbol for hours]... 8 AM... 4 PM... 12 AM... Novolin R Sliding Scale... 181-220-4U..."

F 333 The facility will ensure that residents are free of any significant medication errors. Nursing staff will administer insulin according to the physician order and within the proper time frame before meals. Pharmacokinetics, Compatibility and Properties provided by the American Society of Consultant Pharmacists for typical dosing administration of insulin relation to meals documented "...Novolin R...onset (In hours, Unless Noted...0.5- (to) 1 (hours)...30 minutes before meals..." Nurse #2 was counseled on this typical dosing and administration of insulin in relation to meals and time to be given. She was counseled on the Rights of giving medication.

9-25
 2011

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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 333 Continued From page 10

F 333

Observations in Resident #1's room in 9/6/11 at 12:05 PM, Nurse #2 administered Novolin R 4U to Resident #1. The accucheck with sliding scale insulin was not ordered for this time. This resulted in a significant medication error.

During an interview at the nurses' station on 9/6/11 at 12:10 PM, Nurse #2 was asked at what times were Resident #1's accuchecks with sliding scale insulin ordered. Nurse #2 stated, "...I checked it and gave the insulin at 12 noon... it's ordered for 12 midnight, 8 AM and 4 PM..."

During an interview in the Director of Nursing's (DON) office on 9/8/11 at 1:58 PM, the DON was asked about the times of Resident #1's accuchecks with sliding scale insulin. The DON confirmed the times for sliding scale were 8 AM, 4 PM and 12 AM (midnight) per physician's order. The DON stated, "...was informed of insulin error by the nurse on the second shift... I already wrote her [Nurse #2] up..."

3. Medical record review for Random Resident (RR) #2 documented an admission date of 6/17/11 with diagnoses of Pneumonia, Hypertension, Atrial Fibrillation and Chronic Obstructive Pulmonary Disease. Review of the physician's orders dated 9/1/11 documented, "...ACCUCHECKS FOUR TIMES DAILY WITH MEALS AND AT BEDTIME... NOVLOG... SLIDING SCALE: 151-180= [amount of insulin to be administered] 2U ...181-220=4U..."

Observations in RR #2's room on 9/8/11 at 11:30 AM, Nurse #2 administered Novolog 4U to RR #2. RR #2 was not served his meal until 12:15 PM which was 45 minutes after the resident

Resident #1 and all residents on Novalog R Insulin will receive his/her accucheck and insulin dose at the right time in correlation to the meal. Nurse #2 was in-serviced about reading her medication orders correctly and giving the right medications at the right time. Nurse #2 was reprimanded as well.

RR #2 had an order for accuchecks 4 times daily with meals and at bedtime; with a Novolog Sliding Scale: 151-180=(amount of insulin to be administered) 2 units. 181-220=4 units were to be given. Nurse #2 administered Novolog 4 units to RR#2 at 11:30. RR#2 was not served his meal until 12:15 which was 45 minutes after the resident received the Novolog insulin. Nurse#2 was counseled on correct giving of regular insulin in correlation to the meal. If resident will not be served his/her meal within 30 minutes a substantial snack will be given to prevent a possible reaction of low blood sugar from the dose of insulin that was given.

9-25
2011

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445470	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/08/2011
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NAME OF PROVIDER OR SUPPLIER ARBOR PLACE OF PURYEAR INC	STREET ADDRESS, CITY, STATE, ZIP CODE 220 COLLEGE STREET PURYEAR, TN 38251
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F 333 Continued From page 11 received the insulin. This resulted in a significant medication error.

F 333

All Licensed Nursing staff will be in-serviced on the ruling of the "Med Pass Common Insulins". The DON and or her designee will give an in-service on the "Med Pass Common Insulins". Nursing staff will be monitored monthly for compliance by the DON and or her designee for compliance. This tag will be monitored by the Quality Assurance Committee monthly until the next survey.

9-25
2011

During an interview in the dining room on 9/6/11 at 12:15 PM, RR #2 was asked if he had eaten anything from the time he received his insulin until his meal was served at 12:15 PM. RR #2 stated, "No."

F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

F 441

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

- (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.

F 441

The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility will establish an Infection Control Program under which it: (1) Investigates, control, 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.

9-25
2011

- (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

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F 441 Continued From page 12
 hand washing is indicated by accepted professional practice.

(c) Linens
 Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
 Based on policy review, observation and interview, it was determined the facility failed to maintain infection control practices to prevent the possible cross-contamination between residents by placing the glucometer on the bedside table without a barrier and not properly cleaning a glucometer during 2 of 4 accuchecks and not properly washing hands by 2 of 3 (Nurses #1 and 2) nurses during medication pass.

The findings included:

1. Review of the facility's "HANDWASHING" policy documented, "...Proper handwashing should be performed between all services to residents... Handwashing is the most important procedure in preventing the spread of disease..."
2. Observations during medication administration on 9/7/11 at 8:45 AM, Nurse #1 entered room 103 and administered medication. Nurse #1 entered room 104 on 9/7/11 at 8:50 AM to administer medication. Nurse #1 did not wash her hands between the medication administration of the two residents.

F 441 (b) Preventing the Spread of Infections (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility will 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 with residents or their food is made this direct contact will transmit the disease.(3) The facility will require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. (c) Linens Personnel will handle, store, process and transport linens so as to prevent the spread of infection.

The facility's "Handwashing" policy documented, "... Proper handwashing should be performed between all services to residents...Handwashing is the most important procedure in preventing the spread of disease..."

9-25
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F 441 Continued From page 13

During an interview at the nurses' station on 9/8/11 at 1:45 PM, Nurse #1 confirmed that she did not wash her hands between administering the medications to the two residents observed.

3. Review of the facility's "USE AND SANITATION OF GLUCOMETER" policy documented, "...The Glucometer should be sanitized by using the Sani-Cloth Germicidal Wipes, before and after use to help prevent the development and transmission of disease and infection... Wash hands and dry, place barrier on a clean bedside table... Using the Sani-Cloth Germicidal Wipe cleanse off the Glucometer... Do the test... Remove your gloves and clean machine using another Sani-Cloth Germicidal Wipe... Place the Glucometer in the locked cart..."

Observations during medication administration in Random Resident (RR) #2's room on 9/8/11 at 11:23 AM, revealed Nurse #2 took the glucometer into RR #2's room, placed the glucometer on the bedside table without a barrier, performed the accucheck and returned the glucometer to the medication cart without cleaning the glucometer. Nurse #2 then obtained insulin, reentered RR #2's room, administered insulin and left the room. Nurse #2 did not wash her hands during this time.

Observations during medication administration in Resident #1's room on 9/8/11 at 12:05 PM, Nurse #2 took the glucometer into Resident #1's room, placed the glucometer on the bedside table without a barrier, performed the accucheck and returned the glucometer to the medication cart without cleaning the glucometer. Nurse #2 obtained insulin, reentered Resident #1's room,

F 441

The nurses will wash their hands between all residents when giving medications or administering care and or treatments. Inservice will be given on policy and procedure of Handwashing per DON and or her designee. The facility's policy and procedure for "use and Sanitation of Glucometer" documents... The glucometer should be sanitized by using the Sani-Cloth Germicidal Wipes, before and after use to help prevent the development and transmission of disease and infection... Wash hands and dry, place barrier on a clean bedside table... Using the Sani-Cloth Germicidal Wipe cleanse off the Glucometer... With gloves on Do the Test... Remove your gloves and clean machine using another Sani-Cloth Germicidal Wipe... Place the glucometer in the locked cart...

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NAME OF PROVIDER OR SUPPLIER ARBOR PLACE OF PURYEAR INC			STREET ADDRESS, CITY, STATE, ZIP CODE 220 COLLEGE STREET PURYEAR, TN 38251		
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F 441	Continued From page 14 administered insulin and left the room. Nurse #2 did not wash her hands during this time. During an interview at the nurses' station on 9/6/11 at 2:55 PM, Nurse #2 was asked when and how she should clean the glucometer. Nurse #2 stated, "...clean the glucometer before and after fingersticks with PDJ wipes [Sani-Cloth Germicidal Wipe]..." Nurse #2 was asked if she cleaned the glucometer during the observed medication administration. Nurse #2 stated, "...I forgot to..." 4. During an interview in the Director of Nursing's (DON) office on 9/8/11 at 1:58 PM, the DON was asked when should staff members wash their hands. The DON stated, "...they need to wash their hands between residents... before and after inhalers and eye drops... when they take off gloves..." The DON was asked when should the nurses clean the glucometer. The DON stated, "...before and after use with Sani Wipes [Sani-Cloth Germicidal Wipe]..."	F 441	Nurse# 2 and all nursing staff were in-serviced on the policy and procedures of use and cleaning of the glucometer, and handwashing policies and procedure. All nursing staff will be in-serviced on these policies and procedures of Infection Control, Use and Cleaning of the glucometer, and handwashing. These tags will be monitored by the Quality Assurance Committee every month until next survey.	9-6-2011	
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure the environment was clean, sanitary and odor free as evidenced by a brown substance	F 465	The facility will provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.		

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F 465 Continued From page 15
buildup on the hopper and foul odor in the soiled linen room on 1 of 2 (hall 1) halls.

The findings included:

Review of the facility's "Cleaning of the Soiled Hopper Room Disposing of Soiled Linen and Incontinent Supplies" policy documented, "It is the policy of this facility to keep the hopper rooms as clean as possible, this will include but is not limited to the hopper itself... to eliminate odors, The hopper will be cleaned and disinfected twice a shift..."

Observation in the soiled linen room on hall 1 on 9/8/11 at 10:55 AM and 4:50 PM and on 9/7/11 at 8:40 AM and 10:20 AM, revealed a foul odor, a large clump of brown substance and several smaller clumps of the brown substances on the hopper.

During an interview in the soiled linen room on hall 1 on 9/7/11 at 2:15 PM, the Director of Nursing (DON) was asked what the brown substance was on the hopper. The DON stated, "probably poop... this is to be cleaned every shift, this smells really funky."

F 465:

The facility's policy and procedure "Cleaning of the Soiled Hopper Room Disposing of Soiled Linen and incontinent Supplies" policy documented, "It is the policy of this facility to keep the hopper rooms as clean as possible, this will include but is not limited to the hopper itself...to eliminate odors,the hopper will be cleaned and disinfected twice a shift..." In-service was given to the nursing staff and housekeeping staff on the Policy for "Cleaning of the Soiled Linen and Incontinent Supplies" Housekeeping will clean hopper and receptacles(barrels) first thing in the AM and least twice a shift and PRN. Trash and dirty rinsed linen will be bagged and emptied every shift and PRN. Visible BM is to clean off any areas of the hopper, floor, or wall with disinfectant. Automatic deodorizer was put up in this area. The Don and or her designee will monitor this area daily and PRN if odors are noticed P&P will be used to eliminate odors. This tag will be monitored by the Quality Assurance Committee until next survey.

9-25
2011