

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

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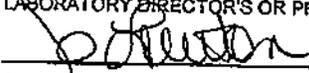
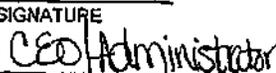
PRINTED: 05/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2011
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NAME OF PROVIDER OR SUPPLIER ASHTON PLACE HEALTH & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3030 WALNUT GROVE RD MEMPHIS, TN 38111
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F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review and observation, it was determined the facility failed to ensure 3 of 16 Certified Nursing Assistants (CNA #11, 13 and 14) knocked on the doors or gained permission prior to entering the resident's rooms.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Review of the facility's "Quality of Life - Dignity" policy documented "...6. Residents' private space and property shall be respected at all times... 6a. Staff will knock and request permission before entering residents' rooms..." Observations on the B wing on 5/9/11 at 5:51 PM, revealed CNA #11 entered room 207 without knocking or gaining permission to entering the room during the supper meal pass. Observations on the A wing on 5/9/11 at 5:42 PM, revealed CNA #13 entered room 110 without knocking or gaining permission to enter the room during the supper meal pass. Observations on the A wing on 5/9/11 at 5:40 PM, revealed CNA #14 entered room 109 without knocking or gaining permission to entering the room during the supper meal pass. 	F 241	<p>The facility will promote care for residents in a manner and an environment that maintains the resident's dignity and respect.</p> <ol style="list-style-type: none"> <ul style="list-style-type: none"> The DON spoke with residents in rooms 207, 110, and 109 on 5/12/11 to reassure them that this was prohibited and would not recur. Social Services will review residents rights regarding dignity and respect of individuality at next resident council meeting 6/9/11. All residents have the potential to be affected by this alleged deficient practice. Social Services will review residents rights regarding dignity and respect of individuality at next resident council meeting on 6/9/11. All staff educated on the importance of maintaining residents dignity and respect of individuality. The Administrator, DON, and social services will complete an audit tool during daily rounds for 4 weeks and PRN to ensure that all staff provides care to residents in an environment that maintains each residents dignity and respect. Social Services Director will report a summary of the findings of audits to the QA committee monthly for the next 3 months for further recommendations and follow up. 	06/08/2011
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE


(X6) DATE
5-24-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</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 physician's orders for elevating extremities, applying bilateral heel boots, applying a chair alarm, obtaining finger stick blood glucose and/or administering insulin for 2 of 25 (Residents #12 and 15) sampled residents.</p> <p>The findings included:</p> <p>1. Medical record review for Resident #12 documented an admission date of 2/8/08 and a readmission date of 3/29/08 with diagnoses of Diabetes, Syphilis, Hypertension, Glaucoma, Alzheimer's and Congestive Heart Failure. Review of the physician's order dated 5/4/11 documented, "...BILATERAL HEEL BOOTS... ELEVATE FEET WHILE IN BED W [with] / PILLOWS... SELF RELEASE SEATBELT TO W/C [wheelchair] ...ELEVATE (L) [left] HAND ON PILLOW WHILE IN BED... CHAIR ALARM TO WHEELCHAIR... KEEP HANDS AND FEET ELEVATED ON PILLOWS WHILE IN BED..."</p> <p>Observations of Resident #12 revealed the</p>	F 309	<p>The facility will continue to provide the necessary care and services to attain or maintain the residents well-being in accordance with the plan of care and comprehensive assessment.</p> <ol style="list-style-type: none"> <ul style="list-style-type: none"> The protective apparel device for resident #12 were discontinued on 5/23/11 with physician order as intervention was no longer appropriate for resident. Resident #12's care plan was updated on 5/24/11 to reflect that this resident does not utilize this protective any longer. Resident #15 was re-assessed for blood sugar parameters and were not affected absence of documentation. The physician was notified of the missed labs. No new orders obtained from the MD. Residents with orders for heel protectors, elevated feet, safety devices such as seatbelts or chair alarms and insulin/accu-check orders have the potential to be affected by this alleged deficient practice. The systematic changes made to ensure that this does not recur is that nursing staff will check at least each shift to ensure residents have appropriate devices in place as physician order dictates. The licensed nursing staff will also check the MAR's daily shift change to 	06/08/2011
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F 309	<p>Continued From page 2 following:</p> <p>a. 5/9/11 at 9:50 AM, seated in a wheelchair in the day room with no chair alarm in place.</p> <p>b. 5/9/11 at 4:05 PM, in bed, feet not elevated, no heel boots on and left hand not elevated on a pillow.</p> <p>c. 5/10/11 at 8:30 AM, seated in a wheelchair in the day room with no chair alarm in place.</p> <p>d. 5/10/11 at 9:52 AM, seated in a wheelchair in the day room with no chair alarm and the self release seatbelt was off.</p> <p>e. 5/10/11 at 4:05 PM, in bed on her right side with feet flat on the bed, no heel boots on and left hand was not elevated on a pillow.</p> <p>f. 5/11/11 at 9:40 AM, seated in a wheelchair in the hall with no chair alarm in place.</p> <p>During an interview in Resident #12's room on 5/10/11 at 4:05 PM, Nurse #10 was asked if Resident #12 had heel boots on, had her feet elevated on pillows, or had her left hand elevated on a pillow. Nurse #10 stated, "...no, she [Resident #12] do not..."</p> <p>During an interview in the day room on 5/11/11 at 11:45 AM, Nurse #10 was asked if Resident #12 had a chair alarm on. Nurse #10 stated, "No."</p> <p>2. Medical record review for Resident #15 documented an admission date of 12/18/07 and a readmission date of 6/11/10 with diagnoses of Diabetes Mellitus, Anemia, Osteoporosis, Hypertension, Delirium and Epilepsy. Review of the physician's orders dated 5/4/11 documented, "...NOVOLIN R... SSI [Sliding Scale Insulin] -SQ [Subcutaneous] ...70- [to] 200= [amount of insulin to be administered] 0U [units], 201-250=2U, 251-300=4U, 301-350=6U, 351-400=8U, OVER</p>	F 309	<p>compare and identify any areas needing attention. Licensed nurses were re-educated on the importance of documentation in the MAR and following physicians orders by the DON and ADON by 6/8/11. The DON and ADON re-educated the certified nursing assistants on the importance of communicating residents non-compliance with interventions to the charge nurse immediately by 6/8/11.</p> <p>4. The DON, ADON, or designee will conduct weekly audits for 4 weeks and then PRN to ensure compliance with regards to appliances/safety interventions being utilized as ordered and compliance with MAR documentation. The DON, ADON, or designee will report findings monthly to the QA committee for the next 3 months for further recommendations and follow up.</p>	

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F 309	<p>Continued From page 3</p> <p>400=10U & [and] RECHECK IN 1 HR [hour] -IF STILL OVER 400=CALL MD [Medical Doctor]... BLOOD GLUCOSE FINGER STICKS 4 TIMES DAILY BEFORE MEALS AND AT BEDTIME..."</p> <p>Review of Resident #15's medication administration records (MAR) documented the following:</p> <p>a. No finger stick blood glucose on 2/4/11 at 9:00 PM, 2/11/11 at 5:00 PM or 9:00 PM; on 2/12/11 at 9:00 PM; 3/16/11 at 12:00 PM or 3/20/11 at 5:00 PM.</p> <p>b. The finger stick blood glucose results was 410 on 2/6/11 at 12:00 PM, 401 on 2/7/11 at 7:00 AM, 402 on 2/13/11 at 7:00 AM, 446 on 2/16/11 at 5:00 PM, 433 on 3/20/11 at 7:00 AM and 455 on 3/20/11 at 12:00 PM. There was no documentation that the finger stick blood glucose was rechecked in one hour for any of these results over 400.</p> <p>c. The blood glucose result was 346 on 2/1/11 at 12:00 PM with 8 units of Novolin R insulin given instead of ordered 6 units.</p> <p>During an interview in the B wing dining room on 5/11/11 at 3:15 PM, Nurse #14 was asked if Resident #15's blood glucose was checked on 2/4/11 at 9:00 PM, 2/11/11 at 5:00 PM and 9:00 PM, 2/12/11 at 9:00 PM, 3/16/11 at 12:00 PM, and 3/20/11 at 5:00 PM. Nurse #14 stated, "... [blood glucose] not documented..." Nurse #14 was asked what her expectation was for nurses to document a blood glucose that was not done. Nurse #14 stated, "...they [nurses] should document it on the back of the sheet [MAR] or in the note [nurses notes]..." Nurse #14 was asked where she expected the nurse to document the blood glucose result when rechecked in 1 hour after a result of 400 or greater. Nurse #14 stated,</p>	F 309			

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F 309	Continued From page 4 "...on the back of the sheet [MAR] or in the note..." Nurse #14 was asked if Resident #15 had ever refused treatments or medications. Nurse #14 stated, "...no, never..." Nurse #14 was asked if the blood glucose had been rechecked on the dates and times, noted above, when the results were over 400 or greater. Nurse #14 stated, "...I don't see where they [blood glucose's] were rechecked... no note..." Nurse #14 was asked what the blood glucose result was on 1/1/11 at 12:00 PM and how much insulin should have been given. Nurse #14 confirmed that the blood glucose result was 346 and stated, "...should have been 6 units [of insulin given]..."	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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 review of the "National Pressure Advisory Panel Pressure Ulcer Prevention QUICK REFERENCE GUIDE", policy review, medical record review, observation and interview, it was determined the facility failed to prevent and identify the development of pressure sore/ulcer for 1 of 12 (Resident #23) sampled residents with a pressure ulcer. The failure to identify and	F 314	F314 The facility will follow the wound protocol to ensure the residents do not develop pressure sores unless it is clinically unavoidable. 1. • As discussed with the survey team on 5/10/11 the facility had identified in February 2011 several discrepancies in wound reports and identification of such through turnover of wound care staff. The facility devised a Wound Care Action Plan in February 2011 and this written plan was reviewed with the survey team evidencing that wounds had not been staged appropriately from prior wound care staff. A full skin sweep was done by wound nurse and wound consultant in February 2011 of all residents to ensure	06/08/2011

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F 314	<p>Continued From page 5</p> <p>prevent skin breakdown prior to the development of an unstageable pressure ulcer resulted in actual harm to Resident #23.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Review of the "National Pressure Advisory Panel Pressure Ulcer Prevention QUICK REFERENCE GUIDE" documented, "p. 9 ...Unstageable/Unclassified: Full thickness skin or tissue loss-depth unknown Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown, or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV. p. 12... 3. Inspect skin regularly for signs of redness... Ongoing assessment of the skin is necessary to detect early signs of pressure damage. 4. Skin inspection should include assessment for localized heat, edema, or induration (hardness), especially in individuals with darkly pigmented skin..." Review of the facility's "Pressure Ulcer Risk Assessment" policy documented, "...General Guidelines... 4. If pressure ulcers are not treated when discovered, they quickly get larger, become very painful for the resident, and often times become infected... 6. Once a pressure ulcer develops, it can be extremely difficult to heal... 9. Pressure ulcers are a serious skin condition for the resident. 10. Routinely assess and document the condition of the resident's skin... Immediately report any signs of a developing pressure ulcer to the supervisor... Assessment... 2. Skin 	F 314	<p>identification of wounds was accurate as well as wound staging was appropriate. The facility had already identified resident #23 to have a wound during this Feb. 2011 skin sweep as stated in the facility action plan for skin assessment . A 100% skin sweep will be completed by 6/3/11 by the Treatment nurses and the unit managers to ensure all skin issues have been identified and appropriate treatment orders has been implemented.</p> <ol style="list-style-type: none"> Residents receiving wound care have the potential to be affected by this alleged deficient practice. The facility will complete a full skin by 6/3/11 on all residents to ensure appropriate treatments were ordered as necessary for those with wounds. DON, ADON, or designee to re-educate the licensed nurses on the policy and procedure for wound management, Braden scales, and pressure relieving devices by 6/8/11. All Braden scale assessments were reviewed by the DON, ADON, or designee to ensure appropriate action had taken place, if needed. Weekly skin assessments are being reviewed at least weekly by the treatment nurse. A review of all resident mattresses was conducted by 		

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F 314	<p>Continued From page 7</p> <p>During an interview at the C wing nurses' station on 5/11/11 at 8:00 AM, Certified Nursing Assistant #7 stated, "The shower aide does these shower sheets [skin check sheets] on everyone on shower days. If there is a skin problem while giving a bed bath, would fill this sheet out and tell the nurse... remember her [Resident #23] skin being dry on her heels... but do not remember any other skin problems..."</p> <p>During an interview in the conference room on 5/11/11 at 12:00 PM, Resident #23's physician stated, "...should not be unstageable [pressure sore] when first discovered... I do think the aides do not always report these skin issues..."</p> <p>The failure to identify and prevent skin breakdown prior to the development of an unstageable pressure ulcer resulted in actual harm to Resident #23.</p>	F 314		
F 315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 315	<p>F315</p> <p>The facility will ensure that residents who are incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <ol style="list-style-type: none"> 1. <ul style="list-style-type: none"> • Resident #8 and Resident #7 – assistive device implemented for these residents to ensure catheter tubing and drainage bag are off the floor. 2. All residents with foley catheters have the potential to 	06/08/2011

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F 315	<p>Continued From page 8</p> <p>Based on review of "Sorensen and Luckmann's Basic Nursing A Psychophysiologic Approach", policy review, medical record review, observation and interview, it was determined the facility failed to provide appropriate catheter care and treatment for 2 of 6 (Residents #8 and 17) sampled residents observed with a catheter.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Review of "Sorensen and Luckmann's Basic Nursing A Psychophysiologic", third edition, page 1187, documented, "...The [Foley catheter] bag and tubing should never touch the floor... These increase the chances for bacteria in the drainage bag to ascend the tubing and possibly to enter the bladder. Bacteria in the drainage bag can lead to UTI [urinary tract infection] and subsequent increased mucus production..." Review of the facility's "Catheter Care, Urinary" policy documented, "...Be sure the catheter tubing and drainage bag are kept off the floor..." Medical record review for Resident #8 documented an admission date of 1/6/11 with a readmission date of 4/7/11 with diagnoses of Stage IV Sacral Decubitus, Chronic Respiratory Failure, Tracheostomy and Quadriplegia. Review of the physician's orders dated 5/4/11 documented, "...FOLEY CATH [catheter] TO DRAINAGE BAG... FOLEY CATH CARE EVERY SHIFT... CHANGE FOLEY CATH EVERY MONTH..." <p>Observation in Resident's #8's room on 5/10/11 at 7:52 AM, revealed Resident #8 lying on the</p>	F 315	<p>be affected by this alleged deficient practice.</p> <ol style="list-style-type: none"> All residents with catheters were assessed by DON, ADON, or designee to ensure the appropriate placement of the drainage bag and tubing to prevent urinary tract infections. DON, ADON or designee to re-educate nursing staff on appropriate positioning of drainage bags and tubing to prevent infection by 6/8/11. DON, ADON, or designee will complete an audit during daily rounds for 4 weeks and PRN to ensure compliance with the placement of catheter bags and tubing. DON, ADON, or designee will report a summary of the findings of audit to the QA committee monthly for the next 3 months and PRN for further recommendations and follow up. 	
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F 315	<p>Continued From page 9 bed with the catheter drainage bag laying on the floor.</p> <p>4. Medical record review for Resident #17 documented an admission date of 9/1/04 with a readmission of 4/8/11 with diagnoses of Prostate Cancer, Dementia, Neurogenic Bladder and Acute Renal Failure. Review of the physician's orders dated 5/4/11 documented, "...FOLEY CATH... CHANGE FOLEY MONTHLY... CHANGE FOLEY DRAINAGE BAG... FOLEY CATH CARE EVERY SHIFT.</p> <p>Observations in Resident #17's room on 5/9/11 at 5:50 PM, revealed Resident #17 lying on the bed with the catheter drainage bag laying on the floor.</p> <p>5. During an interview in the conference room on 5/11/11 at 1:00 PM, the Director of Nursing (DON) was asked if it was acceptable for a Foley bag to ever be on the floor. The DON stated, "...No..."</p>	F 315		
F 322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review,</p>	F 322	<p>F322</p> <p>The facility will ensure that a resident who is fed by a gastrostomy (PEG) tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <ol style="list-style-type: none"> Resident #9 – Physician was notified that the tube feeding was not infusing at the ordered rate of 85 cc/hr, order clarified and new order given for 65 	06/08/2011

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F 314	<p>Continued From page 6</p> <p>Assessment. Skin will be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated... 3. b. Nurses are to be notified to inspect the skin if changes are identified..."</p> <p>3. Medical record review for Resident #23 documented an admission date of Diabetes, Cerebrovascular Disease, Depressive Psychosis, Hypertension, Hyperlipidemia, Peripheral Vascular Disease and Anemia. Review of the skin check sheets dated 2/8/11, 2/10/11, 2/12/11, 2/15/11, 2/17/11 and 2/19/11 documented no open areas. Review of the skin body assessment sheets dated 1/31/11, 2/7/11, 2/14/11 and 2/21/11 documented no areas of skin impairment. Review of the weekly pressure ulcer record documented an unstageable pressure ulcer with an onset date of 2/22/11 with slough present to the wound bed. Review of the nurses' notes dated 2/22/11 documented, "L [left] heel noted c [with] small area... put in bk [book] for eval [evaluation], order noted to float heel while in bed..."</p> <p>Observations in Resident #23's room on 5/10/11 at 10:00 AM, revealed Resident #23's left heel pressure ulcer was a stage II, 1/2 centimeter open area, with pink scar tissue surrounding the open area. The open area was red in color.</p> <p>During an interview in the conference room on 5/10/11 at 4:50 PM, Nurse #11 confirmed the left heel wound was unstageable when discovered and stated, "There was slough and eschar when found it [pressure sore]. Her [Resident #23] skin was fine before this and was intact. It was facility acquired."</p>	F 314	<p>DON or designee to ensure correct mattress placement for residents. A weekly review of wounds, treatment orders and care plans will be completed by the DON and Interdisciplinary Team in the weekly wound meeting to ensure compliance with the wound care and care plan policy.</p> <p>4. The DON or designee will conduct weekly audits of the weekly skin assessment weekly wound documentation and wound care plans in the weekly wound meeting for the next 4 weeks and then PRN to ensure compliance. The DON or designee will report findings monthly to the QA committee for the next 3 months for further recommendation and follow up.</p>	

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F 322	<p>Continued From page 10</p> <p>observation and interview, it was determined the facility failed to ensure staff provided care according to their policy for medication administration per a percutaneous endoscopy gastrostomy (PEG) tube and failed to follow a physician's order for the rate the tube feeding was to be administered for 2 of 7 (Residents #9 and 10) sampled residents with PEG tubes and Random Resident (RR) #1.</p> <p>The findings included:</p> <p>1. Medical record review for Resident #9 documented an admission date of 2/4/05 with a readmission date of 1/27/11 with diagnoses of Gastrostomy, Failure to Thrive, Dysphagia, Alzheimer's and Hypertension. Review of the physician's order dated 4/5/11 documented, "...TUBE FEED: FIBERSOURCE HN @ [at] 85CC [cubic centimeters] / [per] HR [hour] X [times] 22 HRS [hours]..."</p> <p>Observations in Resident #9's room on 5/9/11 at 10:40 AM, 4:15 PM and 5:50 PM and on 5/10/11 at 7:55 AM, 11:00 AM, 3:55 PM and 5:55 PM, revealed Resident #9's tube feeding was infusing at 65 cc/hr, not the ordered rate of 85 cc/hr.</p> <p>During an interview in Resident #9's room on 5/10/11 at 3:55 PM, Nurse #9 was shown the physician's orders for the tube feeding and asked to confirm the current flow rate of Resident #9's feeding. Nurse #9 confirmed Resident #9's tube feeding was not infusing at the ordered rate of 85 cc/hr.</p> <p>2. Review of the facility's "Administering Medications through an Enteral Tube" policy,</p>	F 322	<p>cc/hr, the 85 cc/hr order was d/c. Nurse #9 received one-on-one training on the proper procedure of infusing tube feeding per physician orders from the DON on 5/24/11</p> <ul style="list-style-type: none"> • Resident #10 – No adverse effect to resident noted. DON re-educated Nurse #2 on the policy of administering medications through an enteral tube on 5/24/11. • Random resident #1 – No adverse effect to resident noted. DON re-educated Nurse #1 on policy of administering medications through an enteral tube, checking for placement of peg tube and flushing the peg tube as policy dictates on 5/24/11. <p>2. Residents requiring nourishment and hydration through an enteral device have the potential to be affected by this alleged deficient practice.</p> <p>3. DON, ADON, or designee to re-educate licensed nursing staff on the appropriate technique for administering medications through an enteral tube, flushing of such and checking for placement by 6/8/11. A weekly medication administration observation will be completed by DON, ADON, or designee on random nurses administering medication through a peg tube to ensure</p>	
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F 322	<p>Continued From page 11 documented "...h. Flush tubing with at least 30 ml. [milliliters] warm water... 21. Administer medication..."</p> <p>Medical record review for Resident #10 documented an admission date of 9/2/10 with a readmission date of 2/2/11 with diagnoses of Malnutrition, Cerebrovascular Accident, Renal and Ureteral Disease, Hypertension, Diabetes and Mental Disorder. Review of the physician's orders dated 5/4/11 documented, "...FLUSH PEG W [with] / 30 CC BEFORE & [and] AFTER MEDS [medications]..."</p> <p>Observations during medication administration on 5/9/11 at 5:08 PM, Nurse #2 poured prepared liquid medication into a 60 cc syringe attached to the PEG tube and pushed the medication through the tube by pushing the plunger on the syringe. Nurse #2 did not flush the tube before administering the medication and Nurse #2 did not allow the medication to flow by gravity. Nurse #2 administered a total of 482 cc of water per syringe flush after administration of the medications.</p> <p>3. Review of the facility's "Administering Medications through an Enteral Tube" policy, documented "...18. For ...gastrostomy tubes, check placement ...b. Auscultate the abdomen... while injecting the air from the syringe into the tubing ...h. Flush tubing with at least 30 ml. [milliliters] warm water... 21. Administer medication..."</p> <p>Medical record review for Random Resident (RR #1) documented an admission date of 5/6/11 with diagnoses of Decubitus Ulcers, Hypertension,</p>	F 322	<p>compliance weekly for four weeks and then monthly for three months.</p> <p>4. DON, ADON, or designee will report a summary of these weekly peg tube medication administration audits to the QA committee monthly for the next 3 months for further recommendations and follow-up.</p>	
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F 322	Continued From page 12 Peripheral Vascular Disease, Anemia and Seizures. Observations during medication administration on 5/9/11 at 2:35 PM, Nurse #1 administered medication to RR #1 by pouring the medication into a syringe attached to the PEG tube with a small amount of water in the cup of medication and allowed the diluted medication to flow by gravity. Nurse #1 did not check for placement of the PEG tube or flush the PEG tube prior to the administration of the diluted medications.	F 322		
F 323 SS=G	483.25(h) FREE OF ACCIDENT 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 facility failed to ensure a safe environment for residents at risk for falls for 7 of 33 (Residents #2, 7, 9, 12, 15, 17 and 30) sampled residents and adequate supervision to prevent elopement for 1 of 33 (Resident #29) sampled residents. The failure of the facility to follow care plan interventions resulted in actual harm when Resident #30 fell with injuries of a 2 centimeter (cm) head laceration and hematoma.	F 323	F323 The facility will ensure that the resident environment remains free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents as identified in residents plan of care. The facility will continue to follow its "Falls & Fall Risk Managing" policy documented...."If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions". • Resident #30 – the associates involved received one-on-one education on 1/14/11 regarding appropriate safety interventions and monitoring of resident for safety.	06/08/2011

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F 323	<p>Continued From page 13 The findings included:</p> <p>1. Review of the facility's "Falls and Fall Risk, Managing" policy documented, "...If falling recurs [reoccurs] despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions..."</p> <p>2. Medical record review for Resident #30 documented an admission date of 1/13/09 with diagnoses of Hypothyroidism, Diabetes Mellitus, Hypertension and Chronic Obstructive Pulmonary Disease. Review of the nurses notes dated 1/3/11 at 6:00 PM documented, "the resident [#30] was on the floor. Resident was found on her knees on the floor next to bed c [with] her hands and head on the bed. Fall was not witnessed." Review of the "Ashton Place Fall Screen" dated 1/4/11 documented the physical therapist performed a therapy screen and documented suggestions that nursing try these strategies and determine if effective: "keep bed in lowest position, siderails up at all times, close supervision when up in gerichair." Review of the of the care plan updated 1/4/11 documented new interventions: "Keep resident in view of staff at all times" and "Resident on q [every] 30 min [minute] checks."</p> <p>Review of the nurses notes dated 1/14/11 at 2:30 PM documented, "resident was observed face down on floor, falling out of geri-chair. Resident was lying on rt. [right] side in front of bedroom door." Review of the nurses notes dated 1/14/11 at 2:40 PM documented the resident was</p>	F 323	<ul style="list-style-type: none"> Resident #2 – safety devices were immediately implemented on 5/11/11 at 5:18 pm and care plan updated for such. Safety devices are checked for appropriate placement at least each shift and Resident #2 have each safety devices in place as ordered. Resident #7 – Geri-chair reclined to appropriate position on 5/11/11 at 5:18 pm. Care plan and order updated accordingly. The associates involved in care of this resident received one-on-one education on 5/24/11 regarding use of Geri chair for safety intervention for this resident. Safety devices are checked for appropriate placement at least each shift and resident #7 continues to have geri-chair reclined and in appropriate position to ensure safety. Resident #9 the associate involved received one-on-one education on 4/12/11 regarding appropriate transfer techniques and following care plan of such. Resident #12 – Bed bolsters were re-applied to resident on 5/10/11 at 4:20 pm. Safety devices are checked for appropriate placement at least each shift and resident #12 continues to have appropriate safety devices in place. Resident #15 – care plan was updated on 5/24/11 to reflect 	
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F 323	<p>Continued From page 14</p> <p>transported via ambulance to the Emergency Room. Review of the "Resident Transfer Form" dated 1/14/11 documented, "Observed resident on floor face down c [with] R [right] side of head large laceration bleeding large hematoma."</p> <p>Review of Resident #30's hospital medical record documented an admission date of 1/14/11 and discharge date of 1/25/11 with diagnoses of Fall, Petechial Hemorrhage in the Right Frontoparietal area, C1 ring Fracture, Dementia, 2 cm Head Laceration, Spondylosis, Hypothyroidism, Diabetes Mellitus and Neuropathy.</p> <p>The failure of the facility to ensure the care plan intervention to keep the resident in view of the staff at all times resulted in actual harm when Resident #30 fell sustaining a 2 cm head laceration and hematoma.</p> <p>3. Medical record review for Resident #2 documented an admission date of 10/14/09 with a readmission date of 4/25/11 with diagnoses of End Stage Renal Disease, Peripheral Vascular Disease, Neurogenic Bladder, Diabetes and Bilateral Below the Knee Amputation. Review of the facility's "Incident/Accident Report" documented Resident #2 had falls on 6/7/10, 10/2/10, 11/5/10 and 11/23/10. Review of the physician's orders dated 5/4/11 documented, "...BED BOLSTERS WHILE IN BED... FLOOR MATS AT BEDSIDE WHILE IN BED... BED ALARM WHILE IN BED... CHAIR ALARM WHILE IN W/C [wheelchair]..."</p> <p>Observations in Resident #2's room on 5/9/11 at 10:23 AM, 12:09 PM and 3:40 PM, on 5/10/11 at 11:30 AM and 3:30 PM and on 5/11/11 at 9:20</p>	F 323	<p>the current interventions in place for fall prevention/safety devices.</p> <ul style="list-style-type: none"> Resident #17 – bed bolsters were reapplied to resident on 5/11/11 at 12:15 pm. Safety devices are checked for appropriate placement at least each shift and resident #17 continues to have appropriate safety devices in place. Resident #29 – No harm whatsoever was noted to this resident. Resident was immediately placed on one-on-one observation until a more secure environment could be established. <p>5. Residents with a safety/assistive device(s) ordered have the potential to be affected by this alleged deficient practice. Training, systematic changes, audits, and a performance improvement program as described below have been implemented to ensure all other residents with safety/assistive devices are consistently being checked for appropriate and safe placement and usage of these devices.</p> <p>6. The DON, ADON or designee trained all licensed nursing staff that all devices ordered for residents must be checked each shift for proper placement on resident and proper functioning and that this check must be documented on each resident's</p>	

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F 323	<p>Continued From page 15</p> <p>AM and 5:10 PM, revealed no bed bolsters, floor mats, bed alarm, or chair alarm in place.</p> <p>During an interview in the conference room on 5/11/11 at 1:15 PM, the Director of Nursing (DON) was asked how the facility ensured the fall interventions were in place. The DON stated, "I can't answer that... it's a nursing function to implement the interventions..."</p> <p>4. Medical record review for Resident #7 documented an admission date of 5/14/10, with a readmission date of 3/31/11 with diagnoses of Hypertension, Hypothyroidism, Urinary Tract Infection, Cerebral Vascular Accident, Dysphagia, Alzheimer's Disease, Foot Ulcer, Chronic Osteomyelitis, Peripheral Vascular Disease and Gastrostomy Tube. Nurses notes documented that the resident had a fall on 1/20/11. The care plan updated 1/20/11 documented the intervention for the "Resident to be reclined when up in geri-chair."</p> <p>Observations in Resident #7's room on 5/10/11 at 3:45 PM, revealed Resident #7 seated upright in a geri-chair.</p> <p>During an interview at the C wing nurses' station on 5/10/11 at 3:46 PM, Nurse #10 was asked what position Resident # 7's geri-chair should be in. Nurse #10 stated, "I'm not sure." When asked how care plan updates were communicated to other care providers, Nurse #7 stated, "...we tell them..."</p> <p>5. Medical record review for Resident #9 documented an admission date of 2/4/05 and a readmission date of 1/27/11 with diagnoses of</p>	F 323	<p>MAR. Licensed nursing staff were also trained that if they find any device to not be working properly they are to replace it with one that is functioning properly and to complete a work order on the device that is not functioning properly. All staff were educated on wandering residents, elopement, safety interventions for such, responding to door alarms, and code green on. The all staff training to be completed by 6/8/11.</p> <p>7. DON, ADON, or designee will audit 10 residents charts and check safety/assistive device placement for the corresponding 10 residents per week for the next 12 weeks to ensure care plan compliance is maintained and to ensure the safety devices are in place and functioning. DON/ADON or designee will report findings to the QA committee for the next 3 months for further recommendations and follow-up.</p>		

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F 323	<p>Continued From page 16</p> <p>Gastrostomy, Failure to Thrive, Dysphagia, Alzheimer's and Hypertension. Review of the Minimum Data Set dated 1/27/11 documented a cognitive summary score reflecting severe impairment. The care plan dated 2/3/11 documented "...half siderails while in bed... 2 person assist when caring for resident..." Review of the fall investigation dated 2/8/11 documented Resident #9's bedrail had been left down on the side of the bed and Resident #9 fell. Review of the fall investigation dated 4/12/11 documented Certified Nursing Assistant (CNA) #9 transferred Resident #9 from chair to bed alone, her feet twisted up in the fall mat beside the bed and CNA #9 and Resident #9 fell to the floor. The staff failed to follow the care plan interventions which resulted in two avoidable falls for Resident #9.</p> <p>During an interview in the Resident #9's room on 5/10/11 at 3:55 PM, Nurse #9 stated the CNAs have access to the care plans and know that if a lift is not available to get two people to transfer a resident.</p> <p>During an interview in Resident #9's room on 5/11/11 at 9:30 AM, CNA #9 stated, "If no lift's available, get two people to transfer her [Resident #9]. Always two people."</p> <p>6. Medical record review for Resident #12 documented an admission date of 2/8/08 with diagnoses of Diabetes, Syphilis, Hypertension, History of Stroke and Glaucoma. Review of the care plan dated 2/25/11 documented bed bolsters as an intervention for falls.</p> <p>Observations in Resident #12's room on 5/9/11 at 3:00 PM and on 5/10/11 at 4:05 PM, revealed</p>	F 323		
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F 323	<p>Continued From page 17</p> <p>Resident #12 in bed with no bed bolsters present.</p> <p>During an interview in Resident #12's room on 5/10/11 at 4:05 PM, the Unit Manager confirmed there were no bed bolsters in place.</p> <p>7. Medical record review for Resident #15 documented an admision date of 12/18/07 and a readmission date of 6/11/10 with diagnoses of Diabetes, Anemia, Osteoporosis, Hypertension, Epilepsy and Dementia. Review of the care plan dated 8/17/10 to present documented a fall on 5/9/10, 6/10/10, 6/14/10, 6/17/10, 7/16/10, 7/28/10, 7/29/10, 8/5/10, 10/7/10 and 11/15/10. There were no new interventions added to the care after the fall on 10/7/10. The care plan documented "...12/23/09-Chair alarm to alert staff of resident attempts at unassisted transfer... 7/29/10-May apply self releasing seat belt. D/C [discontinue] chair alarm."</p> <p>During an interview in the B wing dining room on 5/11/11 at 3:15 PM, Nurse #14 was asked if there were any new interventions on the care plan after each fall. Nurse #14 stated, "...I don't see them here... I'll have to look at the I [Incident] and A [Accident] reports..."</p> <p>During an interview in the conference room on 5/11/11 at 5:25 PM, Nurse #14 was asked if all nurses have the I and A report readily available when providing care. Nurse #14 stated, "No." When asked if the intervention written on the I and A report should be transferred to the care plan, Nurse #14 stated, "Yes."</p> <p>8. Medical record review for Resident #17 documented an admission date of 9/1/04 with a</p>	F 323		

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F 323	<p>Continued From page 18</p> <p>readmission date of 4/8/11 with diagnoses of Prostate Cancer, Dementia, Neurogenic Bladder and Acute Kidney Failure. Review of the care plan dated 4/19/11 documented, "...Bolsters to bed..."</p> <p>Observations in Resident #17's room on 5/9/11 at 10:10 AM, 12:09 PM, 4:45 PM and 5:50 PM, on 5/10/11 at 7:54 AM and 11:28 AM and on 5/11/11 at 8:30 AM and 11:24 AM, revealed no bed bolsters in place.</p> <p>During an interview at the E wing nurses' station on 5/11/11 at 11:18, Nurse #6 confirmed that there were no bed bolsters in place for Resident #17.</p> <p>9. Medical record review for Resident #29 documented an admission date of 1/14/11 with diagnoses of Hypertension, Alzheimer's Disease, Dementia and Muscle Weakness. Review of the "Elopement Risk Assessment" dated 1/14/11 documented Resident #29 had the ability to move about the facility independently and had a history of wandering. Review of the nurses notes dated 1/14/11 at 6:00 PM, documented Resident #29 "makes statement about wanting to go home Wander guard on L [left] ankle."</p> <p>Review of the facility's elopement investigation dated 4/17/11 for Resident #29 documented on 4/17/11 at 8:46 AM "the resident entered the code to open the door and went down E Wing staircase... at 8:47 AM the resident exited D Wing back door... at 10:27 AM the staff on E wing noticed the resident missing and called a Code Green (discovery of missing resident) ...at 11:15 AM the resident was found at a fire station ...</p>	F 323		
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F 323	<p>Continued From page 19 11:35 AM resident returned to the facility via police car."</p> <p>Review of the facility's "Elopement Prevention and Management Program" documented "...Hourly checks (enough staff to monitor resident, properly respond to alarms or alert that indicated door has been opened."</p> <p>During an interview in the Administrator's office on 5/11/11 at 5:00 PM, the Administrator stated when the staff heard the alarm sounding from the D wing back door, they performed a room to room check and they thought the resident had gone to the church activities because she had told them that was where she was going.</p> <p>The facility failed to properly respond by checking the resident when an alarm sounded indicating a door had been opened.</p>	F 323		
F 328 SS=E	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 328	<p>F328 The facility will continue to ensure that the residents receive proper treatment and care for special services.</p> <ol style="list-style-type: none"> 1. <ul style="list-style-type: none"> • Oxygen orders were reviewed with physician and order clarification completed for resident #'s 8, 9, 14, 20 and 24. Resident #8, #9, #14, #20 and #24 were not adversely affected by this practice. 2. All residents with oxygen services have the potential to be affected by this alleged deficient practice. 	06/08/2011

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F 328	<p>Continued From page 20</p> <p>Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure oxygen (O2) therapy was provided as ordered by the physician for 5 of 9 (Residents #8, 9, 14, 20 and 24) sampled residents receiving oxygen.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility's oxygen administration policy documented, "...The purpose of this procedure is to provide guidelines for safe oxygen administration. 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration..." 2. Medical record review for Resident #8 documented an admission date of 1/6/11 and a readmission date of 4/7/11 with diagnoses of Quadriplegia, Status Post Head Injury With Intracranial Hemorrhage, Chronic Respiratory Failure, Tracheostomy, Stage IV Sacral Decubitus. Review of the physician's orders dated 5/4/11 documented, "... O2 [oxygen] @ [at] 3L [liters] PER NC [nasal cannula]... TRACH COLLAR..." <p>Observations in Resident #8's room on 5/9/11 at 9:48 AM and 2:15 PM and on 5/10/11 at 7:52 AM, 9:40 AM and 6:50 PM, revealed Resident #8 lying in bed with the oxygen rate set at 4 liters per minute (LPM).</p> <p>Observations in Resident #8's room on 5/10/11 at 3:10 PM, revealed Resident #8 sitting in the geri chair with the oxygen rate set at 4 LPM.</p>	F 328	<ol style="list-style-type: none"> 3. Facility has now employed a full time Respiratory therapist who will oversee all respiratory services for facility residents. The DON, ADON, or Respiratory Therapist to review oxygen utilization of all residents using oxygen to ensure orders are appropriate. DON, ADON, or designee to educate licensed nursing staff on the importance of following physician orders, assessing residents' respiratory changes and notification of such changes to result in increase or decrease of oxygen utilization to ensure order is appropriate by 6/8/11. The DON, ADON, or designee will audit the MAR's and TAR's and concentrators on random residents with orders for oxygen for the next 12 weeks to ensure oxygen setting is set appropriately and documented as ordered by the physician. 4. DON or designee will report findings of audit to the QA committee monthly for the next three months for further recommendations and follow up. 		

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F 328	<p>Continued From page 21</p> <p>During an interview in the B wing dining room on 5/11/11 at 3:10 PM, Nurse #14 confirmed that Resident #8's oxygen rate "...should be on 3 liters..."</p> <p>3. Medical record review for Resident #9 documented an admission date of 2/4/05 with a readmission date of 1/27/11 with diagnoses of Gastrostomy, Failure to Thrive, Dysphagia, Alzheimer's and Hypertension. Review of the physician's order dated 4/5/11 documented, "...O2 @ 2L/M [liters per minute] BNC [binasal cannula]..."</p> <p>Observations in Resident #9's room on 5/9/11 at 10:40 AM, 12:20 PM, 2:30 PM, 4:15 PM and 5:50 PM and on 5/10/11 at 7:55 AM, 11:00 AM, 3:55 PM and 5:55 PM, Resident #9 did not have oxygen on and that there was no oxygen concentrator in the room.</p> <p>During and interview in Resident #9's room on 5/10/11 at 3:55 PM, Nurse #9 was shown the physician's orders for oxygen. Nurse #9 confirmed that the oxygen was not being given as ordered.</p> <p>4. Medical record review for Resident #14 documented an admission date on 1/29/10 with diagnoses of Congestive Heart Failure, General Weakness, Peripheral Vascular Disease and Hypertension. Review of the physician's order dated 5/4/11 documented, "...O2 @ 2L VIA BNC..."</p> <p>Observations in Resident #14's room on 5/9/11 at 10:00 AM, revealed Resident #14 was receiving O2 at 3.5 LPM per BNC.</p>	F 328		
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F 328	<p>Continued From page 22</p> <p>Observations in Resident #14's room on 5/9/11 at 5:10 PM and on 5/10/11 at 7:55 AM, 10:20 AM and 5:55 PM, revealed Resident #14 receiving O2 at 3 LPM per BNC.</p> <p>During an interview in Resident #14's room on 5/11/11 at 6:00 PM, the surveyor asked what was the correct O2 rate for Resident #14. Nurse #9 stated, "I'm going to go ahead and correct." Nurse #9 adjusted the O2 to the correct rate of 2 LPM.</p> <p>5. Medical record review for Resident #20 documented an admission date on 8/28/07 and readmission date of 3/26/08 with diagnoses of Weakness, Hyperlipidemia, Hypertension, Obesity, Dementia, Diabetes, Peripheral Neuropathy and Hyperthyroidism. Review of the current physician's order revealed there was no order for Resident #20 to receive oxygen.</p> <p>Observations in Resident #20's room on 5/9/11 at 10:15 AM and on 5/11/11 at 8:00 AM, revealed Resident #20 in bed receiving O2 at 3 LPM.</p> <p>During an interview at the A wing nurses station on 5/11/11 at 8:20 AM, the surveyor asked where the order was for Resident #20's O2. Nurse #15 looked though the physician's orders and stated, "I don't see it."</p> <p>6. Medical record review for Resident #24 documented an admission date of 1/31/11 and a readmission date of 2/4/11 with diagnoses of Chronic Obstructive Pulmonary Disease, Lung Cancer and Diabetes. Review of the current physician's orders dated 5/4/11 did not include an</p>	F 328		
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F 328	Continued From page 23 order for Resident #24 to receive oxygen. A physician's order dated 3/30/11 documented, "...Hospice arrange for portable O2 tank for wheelchair..." Observations in Resident #24's room on 5/9/11 at 9:52 AM, on 5/10/11 at 6:20 PM and on 5/11/11 at 8:15 AM, revealed Resident #24 was receiving O2 at 2:5 LPM. There was no portable O2 tank for Resident #24's wheelchair. During an interview at the E wing nurses' station on 5/11/11 at 8:27 AM, Nurse #7 was asked about Resident #24 receiving oxygen. Nurse #7 stated, "...there's not an O2 order on the current physician's orders..." During an interview in Resident #24's room on 5/11/11 at 8:15 AM, Resident #24 stated, "...I can't get out of the room, because I don't have a [portable oxygen] tank... I have asked them [staff] to get me one, but I still don't have one..." During an interview at the E wing nurses' station on 5/11/11 at 8:30 AM, Nurse #7 stated, "Hospice said she [Resident #24] had one at one time, but it disappeared... we have O2 tanks here..."	F 328		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE 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 the "MED-PASS COMMON	F 332	F332 The facility will ensure that it is free of medication error rates of five percent or greater. I. • Resident #10, Random resident #2, Random resident #3, Random resident #4's attending physician's were notified. The resident's were assessed with no adverse effects noted.	06/08/2011

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F 332	<p>Continued From page 24</p> <p>INSULINS: Pharmacokinetics, Compatibility, and Properties" provided by the American Society of Consultant Pharmacists, review of the "MEDICATION GUIDE for the Long-Term Care Nurse", medical record review, observation and interview, it was determined the facility failed to ensure 2 of 8 (Nurses #2 and 4) nurses administered medications with a medication error rate of less than 5 percent (%). A total of 6 medication errors were observed out of 43 opportunities for error, resulting in a medication error rate of 13.9%.</p> <p>The findings included:</p> <p>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 insulins related to meals documented, "Humulin R... ONSET (In hours Unless Noted) ...0.5 [1/2 hour] - [to] 1 [hour]... TYPICAL ADMINISTRATION/COMMENTS ...30 minutes prior to meals..."</p> <p>Medical record review for Resident #10 documented an admission date of 9/2/10 with a readmission date of 2/2/11 with diagnoses of Cerebrovascular Accident, Malnutrition, Renal and Ureteral Disease, Hypertension, Diabetes and Mental Disorder. A physician's order dated 5/4/11 documented "...FERROUS SULF [Sulfate] 220MG [milligrams] / [per] 5ML [milliliters] EL [elixir] TAKE 5MLS (220mg) PER PEG [Percutaneous Endoscopy Gastrostomy] TUBE 2 TIMES DAILY... HUMULIN R 100U [units] /ML VIAL... SS [SLIDING SCALE] SQ [subcutaneous] ...251-300 [blood sugar] = [amount of insulin to be</p>	F 332	<ol style="list-style-type: none"> 2. Any resident receiving medications has the potential to be affected by this alleged deficient practice. 3. DON, ADON, or designee to re-educate the licensed nurses on the policy and procedures for medication administration by 6/8/11. The DON, ADON, or designee will complete medication pass observation audits three times a week for four weeks and PRN thereafter as deemed appropriate. 4. DON, ADON or designee will report findings of these audits to the QA committee monthly for the next 3 months for further recommendations and follow-up. 	
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F 332	<p>Continued From page 25 administered] 6U..."</p> <p>Observations in Resident #10's room on 5/9/11 at 5:18 PM, Nurse #2 administered Ferrous Sulfate liquid to Resident #10. After completion of administration of the liquid medication there was a small amount of brown liquid remaining in the medicine cup. There remained an unknown amount of medication in the cup which resulted in medication error #1.</p> <p>During an interview beside Resident #10's room in the C wing on 5/9/11 at 5:22 PM, Nurse #2 was asked if the medication pass was complete for this resident. Nurse #2 confirmed the medication pass was complete by stating "Mm hmm..."</p> <p>Observations in Resident #10's room on 5/9/11 at 5:33 PM, Nurse #2 administered 6 units of Humulin R insulin to Resident #10. Observations in Resident #10's room on 5/9/11 at 6:15 PM, revealed Resident #10 was not served a pleasure tray nor was his PEG tube feeding started at 6:15 PM, 42 minutes after the administration of the Humulin R insulin which resulted in medication error #2.</p> <p>2. Medical record review for Random Resident (RR) #2 documented an admission date of 9/1/04 with diagnoses of Congestive Heart Failure, Osteoarthritis, Convulsions and Seizure Disorder. Review of physician's order dated 5/4/11 documented, "...AKWA TEARS DROPS INSTILL 1 DROP IN EACH EYE 2 TIMES DAILY (DRY EYES)..."</p> <p>Observations in RR #2's room on 5/10/11 at 9:00 AM, revealed Nurse #4 did not administer the</p>	F 332		
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F 332	<p>Continued From page 26</p> <p>AKWA TEARS DROPS to RR #2. Failure to administer the ordered eye drops resulted in medication error #3.</p> <p>3. Medical record review for RR #3 documented an admission date of 9/1/04 and a readmission date of 6/30/10 with diagnoses of Chronic Airway Obstruction, Cardiac Dysrhythmias, Hypertension and Dementia. Review of a physician's order dated 5/4/11 documented, "...LISINOPRIL 20 MG [milligram] TABLET TAKE 1 TABLET BY MOUTH DAILY *HOLD FOR SBP [systolic blood pressure] BELOW OR EQUAL TO 110... METOPROLOL 100MG TABLET TAKE 1 TABLET BY MOUTH 2 TIMES DAILY *HOLD FOR SBP BELOW OR EQUAL TO 110 OR HR [heart rate] BELOW OR EQUAL TO 55..."</p> <p>Observations in RR #3's room on 5/10/11 at 9:00 AM, Nurse #4 administered Lisinopril 20 mg and Metoprolol 100 mg to RR #3. Nurse #4 did not check the blood pressure or apical heart rate of RR #3 prior to administering these medications. This resulted in medication errors #4 and 5.</p> <p>During an interview on the C wing beside the medication cart on 5/10/11 at 9:45 AM, Nurse #4 was asked if she took RR #3's vital signs. Nurse #4 stated, "...No, the CNAs [Certified Nursing Assistants] do this..."</p> <p>During an interview in the conference room on 5/11/11 at 12:48 PM, the Director of Nursing (DON) was asked who has the responsibility for taking vital signs on residents with specific guidelines for holding or giving medications. The DON stated "...the nurse..."</p>	F 332		
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F 332	Continued From page 27 4. 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 RR #4 documented an admission date of 11/24/10 with diagnoses of Congestive Heart Failure, Chronic Airway Obstruction and Hypertension. Review of a physician's order dated 5/4/11 documented, "...SYMBICORT 160/4.5 MCG [micrograms] INH [Inhaler] INHALE 2 PUFFS BY MOUTH 2 TIMES DAILY..." Observations in RR #4's room on 5/10/11 at 9:12 AM, Nurse #4 administered two inhalations of Symbicort to RR #4, with no time between each puff, and no instruction to RR #4 to hold his breath for 10 seconds. Failure to wait 1-2 minutes between puffs resulted in medication error #6.	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 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: Pharmacokinetics, Compatibility, and Properties" 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 2 of 8 (Nurses #2 and 4) nurses administering medications failed to administer insulin within the proper time frame	F 333	F333 The facility will ensure that residents are free of any significant med errors. 1. <ul style="list-style-type: none"> Resident #10 and random resident #3 had their physician notified and order given for resident #10 for bolus feeding due to tube feeding starting at 6:15 pm. No adverse effects noted to resident #10 or to random resident #3. 2. Residents receiving medications have the potential to be affected by this alleged deficient practice.	06/08/2011

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F 333	<p>Continued From page 28</p> <p>before meals and/or ensure the blood pressure and apical heart rate was taken before administration of an anti-hypertensive medication.</p> <p>The findings included:</p> <p>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 insulins related to meals documented, "Humulin R... ONSET (In hours Unless Noted) ...0.5 [1/2 hour] - [to] 1 [hour]... TYPICAL ADMINISTRATION/COMMENTS ...30 minutes prior to meals..."</p> <p>Medical record review for Resident #10 documented an admission date of 9/2/10 with a readmission date of 2/2/11 with diagnoses of Cerebrovascular Accident, Malnutrition, Renal and Ureteral Disease, Hypertension, Diabetes and Mental Disorder. A physician's order dated 5/4/11 documented "...HUMULIN R 100U [units] /ML VIAL... SS [SLIDING SCALE] SQ [subcutaneous] ...251-300 [blood sugar] = [amount of insulin to be administered] 6U..."</p> <p>Observations in Resident #10's room on 5/9/11 at 5:33 PM, Nurse #2 administered 6 units of Humulin R insulin to Resident #10. Observations in Resident #10's room on 5/9/11 at 6:15 PM, revealed Resident #10 was not served a pleasure tray nor was his Percutaneous Endoscopy Gastrostomy (PEG) tube feeding started at 6:15 PM, 42 minutes after the administration of the Humulin R insulin which resulted in a significant medication error.</p>	F 333	<p>3. DON, ADON or designee to educate licensed nursing staff on medication administration policy and procedure by 6/8/11. DON, ADON, or designee to complete medication pass observation audits three times a week for four weeks and then PRN as deemed appropriate to ensure that resident receives nutritional means within 30 minutes of receiving an insulin injection.</p> <p>4. DON, ADON or designee to report findings of audit to the QA committee monthly for the next three months for further recommendations and follow up.</p>		

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F 333	Continued From page 29 2. Medical record review for Random Resident (RR) #3 documented an admission date of 9/1/04 and a readmission date of 6/30/10 with diagnoses of Chronic Airway Obstruction, Cardiac Dysrhythmias, Hypertension and Dementia. Review of a physician's order dated 5/4/11 documented, "...LISINOPRIL 20 MG [milligram] TABLET TAKE 1 TABLET BY MOUTH DAILY *HOLD FOR SBP [systolic blood pressure] BELOW OR EQUAL TO 110... METOPROLOL 100MG TABLET TAKE 1 TABLET BY MOUTH 2 TIMES DAILY *HOLD FOR SBP BELOW OR EQUAL TO 110 OR HR [heart rate] BELOW OR EQUAL TO 55..." Observations in RR #3's room on 5/10/11 at 9:00 AM, Nurse #4 administered Lisinopril 20 mg and Metoprolol 100 mg to RR #3. Nurse #4 did not check the blood pressure or apical heart rate of RR #3 prior to administering these medications. This resulted in significant medication errors. During an interview on the C wing beside the medication cart on 5/10/11 at 9:45 AM, Nurse #4 was asked if she took RR #3's vital signs. Nurse #4 stated, "...No, the CNAs [Certified Nursing Assistants] do this..." During an interview in the conference room on 5/11/11 at 12:48 PM, the Director of Nursing (DON) was asked who has the responsibility for taking vital signs on residents with specific guidelines for holding or giving medications. The DON stated "...the nurse..."	F 333			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431	F431 The facility will ensure that medications are stored in locked compartments and/or medication storage areas to ensure storage of such in a clean, safe	06/08/2011	

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F 431	<p>Continued From page 30</p> <p>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 1976 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> <p>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</p>	F 431	<p>and sanitary manner.</p> <ol style="list-style-type: none"> 1. <ul style="list-style-type: none"> • Nurse #3 and nurse #20 received one-on-one education on 5/12/11 on the appropriate policies and procedures for medication storage in locked compartments with only authorized personnel having keys to this compartment. 2. All residents in the facility have the potential to be affected from this alleged deficient practice. 3. DON, ADON or designee will make rounds to ensure that appropriate medication storage procedures are being followed. DON or designee will re-educate all licensed staff on the proper storage of medication by 6/8/11. 4. Findings of the rounds and observations will be reported to DON or designee and will be referred to the QA Committee monthly for the next 3 months for further recommendations and follow up. 		

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F 431	<p>Continued From page 31</p> <p>compartments in 2 of 19 (D wing medication cart and 1st floor medication room) medication storage areas.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Review of the facility's "STORAGE OF MEDICATIONS" policy documented, "...2. The nursing staff should be responsible for maintaining storage and preparation areas in a clean, safe and sanitary manner... 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others..." Observations on the D wing, outside of room 189, on 5/9/11 at 11:49 PM, Nurse #3 left the D wing medication cart unlocked, unattended and out of her view. <p>During an interview in front of room 189 on 5/9/11 at 11:50 AM, Nurse #3 verified the D wing medication cart was unlocked.</p> <ol style="list-style-type: none"> Observations in the 1st floor medication room on 5/10/11 at 9:00 AM, revealed the door was standing open. There was medication stored in the unlocked medication room. <p>During an interview at the 1st floor nursing station on 5/10/11 at 8:30 AM, Nurse #20 verified that the door to the 1st floor medication room was unlocked due to cleaning.</p>	F 431		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

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F 441 SS=E	Continued From page 32 SPREAD, LINENS 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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F441 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. 1. • All direct care staff will be in serviced on hand washing and infection control policy by the DON or designee by 6/8/11. 2. All residents have the potential to be affected by this alleged deficient practice. Training, systematic changes, audits, and a quality assurance improvement program as described below have been implemented to ensure compliance is achieved and maintained. 3. DON, ADON or designee will in-service all direct care staff on hand washing and infection control policy by 6/8/11. Direct care associates to also perform a return demonstration on proper hand washing to DON, ADON, or designee after this in-service is completed to ensure each direct care staff checks off on this skill as necessary. DON, ADON, or designee will conduct hand washing audits on all 3 shifts to ensure hand washing procedures are being followed.	06/08/2011	

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F 441	<p>Continued From page 33</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure 7 of 21 (Nurses #1, 4, 5, 11, 12, 16 and 17) nurses and 6 of 16 Certified Nurse Assistants (CNAs #3, 10, 12, 13, 14 and 16) failed to prevent the potential spread of infection by not washing hands, handled food with bare hands, failed to use gloves/and or a gown in an isolation room, failed to set up a barrier during a dressing change, failed to change gloves after removing a contaminated dressing or failed to clean a contaminated bedside table of a resident in isolation.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility's "Infection Control Guidelines for All Nursing Procedures" policy documented, "...1. Standard Precautions will be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases..." Review of the facility's "Handwashing/Hand Hygiene" policy documented, "This facility considers hand hygiene the primary means to prevent the spread of infections... 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors... 5. c. Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice)... e. Before and after entering isolation precaution settings... f. Before and after eating or handling food. g. 	F 441	<p>Ten direct care staff will be audited per week for four weeks to ensure compliance with hand washing and infection control policy and procedures is achieved. Any non-compliance will be addressed through further training and/or disciplinary process.</p> <ol style="list-style-type: none"> 4. DON, ADON, or designee will report findings to the QA committee monthly for three months for further recommendations and follow up. 	
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F 441	<p>Continued From page 34</p> <p>Before and after assisting a resident with meals... k. Before and after changing a dressing... l. Upon and after coming in contact with a resident's intact skin... o. After contact with a resident with infectious diarrhea including, but no limited to infections caused by... C. [Clostridium] Difficile hand washing with soap and water... t. After removing gloves... v. After completing duty... 8. The use of gloves does not replace handwashing/hand hygiene... Washing hands... Dry hands thoroughly with paper towels and then turn off faucets with clean, dry paper towel..."</p> <p>2. Observations during medication administration in Random Residents (RR) #1's room on 5/9/11 at 2:20 PM, Nurse #1 administered medication per percutaneous endoscopy gastrostomy (PEG) and failed to use hand hygiene upon completion of administering medication per a PEG tube.</p> <p>3. Observations during medication administration in RR #2's room on 5/9/11 at 8:20 AM, Nurse #4 did not use hand hygiene before medication administration.</p> <p>4. Observations in the E wing hallway on 5/9/11 at 6:25 PM, Nurse #5 removed a meal tray from the cart, delivered the tray to room 291, set the tray on the bedside table, elevated the head of the bed and left the room. Nurse #5 removed a meal tray from the cart, delivered the tray to room 282 in which Resident #17 was in contact isolation for Clostridium Difficile. Nurse #5 moved the wheelchair, picked up the catheter drainage bag, placed the bag in the privacy bag and left the room. Nurse #5 did not wear gloves or wash her hands.</p>	F 441		

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F 441	<p>Continued From page 35</p> <p>5. Review of the facility's "Wound Care" policy documented, "...1. Use of disposable cloth (paper towel is adequate) to establish clean field on resident's overbed table... 4. Put on exam glove. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands. thoroughly..."</p> <p>a. Observations during a dressing change in Resident #25's room on 5/10/11 at 10:00 AM, Nurse #11 failed to place a barrier on the bedside table for dressing change supplies. During the dressing change, Nurse #11 failed to wash her hands and change gloves after removing the old dressing. After the dressing change, Nurse #11 removed multidose soap and wound cleaner bottles and a package of 4 by (x) 4's out of Resident #25's room, and placed them into the treatment cart.</p> <p>b. Observation during a dressing change inside RR #5's room on 5/10/11 at 1:00 PM, Nurse #12 failed to place a barrier on the bedside table for dressing change supplies.</p> <p>6. Observations in room 266 on 5/9/11 at 6:05 PM, Nurse #16 pulled the resident up in bed, repositioned the resident's legs, elevated the head of the bed, set up the supper tray, opened condiments, handled silverware and cut the meat without washing his hands.</p> <p>7. Observations in the resident day room on A wing on 5/9/11 at 5:45 PM, Nurse #17 dropped a pair of glasses on the floor, picked them up and began to assist residents with supper without washing her hands.</p>	F 441		

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F 441	Continued From page 36 8. Review of the facility's "CONTACT PRECAUTIONS" documented, "...In addition to standard precautions, contact precautions must be implemented for a resident known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or patient care items in the resident's environment... Gloves and Hand Washing... wear gloves (clean, nonsterile) when entering the room... Remove gloves before leaving the room and wash hands immediately with antimicrobial an agent of waterless antiseptic agent.. Gown... wear a gown (clean, nonsterile) when entering a room if you anticipate that your clothing will have substantial contact with with the patient, environmental surfaces, or items in the patient room; if the resident is incontinent; or if the resident has diarrhea, an ileostomy, a colostomy, or wound drainage not contained by a dressing..." Observations in room 282 on 5/9/11 at 3:58 PM, CNA #3 moved the bedside table and the wheelchair without donning gloves or gown and left the room without washing her hands. The resident was in contact isolation for Clostridium Difficile. Observations in room 282 on 5/9/11 at 4:45 PM, CNA #3 pushed Resident #17's wheelchair into the bathroom, pushed the isolation cart from Resident #17's room to the hallway, pulled the floor mat over, pulled the bedside table beside the resident, raised the head of the bed, placed call light across the resident, left the room, and sat in a chair in the hallway beside the E wing	F 441		

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F 441	<p>Continued From page 37</p> <p>nurses' station. CNA #3 did not wear gloves or a gown and did not wash her hands.</p> <p>Observations in the E wing hallway on 5/9/11 at 6:17 PM, CNA #3 removed a meal tray from the cart, delivered the tray to room 288 in which Resident #2 was in contact isolation for Methicillin Resistant Staphylococcus Epidermis. CNA #3 placed the tray on the bedside table, touched her hair with her right hand, and then touched Resident #2's straw. CNA #3 left Resident #2's room, removed a meal tray from the cart, and delivered the tray to room 290. CNA #3 placed the tray on the bedside table, opened the canned drink, and left the room. CNA #3 removed a meal tray from the cart, delivered the tray to room 293, assisted the resident to sit up in bed, moved the resident's wheelchair back from the side of the bed, and then touched the resident's straw. CNA did not wear gloves or wash her hands.</p> <p>Observations in room 282 on 5/10/11 at 9:15 AM, revealed CNA #3 touched the bedside table with her gloved hand after removing a soiled brief from Resident #17 who was in contact isolation for Clostridium Difficile. CNA #3 failed to clean the bedside table and did not wear a gown during the resident's perineal care.</p> <p>During an interview in the conference room on 5/11/11 at 1:00 PM, when asked what the facility's expectation of staff during care of a resident in contact isolation, the Director of Nursing (DON) stated, "...if they touch the bed or resident--gloves and gowns..."</p> <p>9. Observations in the restorative dining in the physical therapy gym on 5/10/11 at 11:50 AM,</p>	F 441		
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NAME OF PROVIDER OR SUPPLIER ASHTON PLACE HEALTH & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3030 WALNUT GROVE RD MEMPHIS, TN 38111
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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
F 441	<p>Continued From page 38</p> <p>CNA #10 opened up a package of crackers and crumbled them up with her bare hands and put the crackers in RR #5's soup.</p> <p>10. Observations in room 232 on 5/9/11 at 5:59 PM, CNA #12 knocked on the door, delivered a meal tray, set up the tray, touched the sandwich with her bare hands, cut it in half, and left the room without washing her hands or using hand gel. CNA #12 then retrieved another meal tray from the cart and delivered it to room 222. CNA #12 set up the tray, touched the sandwich with her bare hands, cut it in half and proceeded to feed the resident. CNA #12 moved the chair closer to the bed, sat down, moved the overbed table closer and continued to feed the resident, without washing her hands or using hand gel.</p> <p>11. Observations in room 124 on 5/9/11 at 5:45 PM, CNA #13 touched the resident's sandwich bread with her bare hands while preparing the meal tray.</p> <p>12. Observations in room 109 on 5/9/11 at 5:37 PM, CNA #14 touched the lettuce and tomato on a sandwich with her bare hands while preparing the meal tray.</p> <p>Observations in the resident day room on A wing on 5/9/11 at 5:55 PM, CNA #14 picked up a container of strawberry ice cream from the floor, picked the container up and continued to assist residents with supper without washing her hands.</p> <p>13. Observations in room 251 on 5/9/11 at 6:00 PM, CNA #16 touched the resident, touched inanimate objects then set up the resident's supper tray by removing the lid, opened the</p>	F 441		

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: 445118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2011
NAME OF PROVIDER OR SUPPLIER ASHTON PLACE HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3030 WALNUT GROVE RD MEMPHIS, TN 38111	
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F 441	Continued From page 39 silverware and other covered food items on tray, cut the meat without washing hands.	F 441		
F 502 SS=D	<p>14. During an interview in the Administrator's office on 5/11/11 at 8:15 AM, the DON stated the above findings were "...an infection control problem..."</p> <p>483.75(j)(1) ADMINISTRATION</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to ensure laboratory (lab) services were completed as ordered by the physician for 2 of 33 (Residents #9 and 22) sampled resident.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Medical record review for Resident #9 documented an admission date of 2/4/05 with diagnoses of Gastrostomy, Failure to Thrive, Dysphagia and Anemia. Review of a physician's order dated 1/22/11 documented to obtain a "...prealbumin..." The facility was unable to provide documentation that the prealbumin was done as ordered. <p>During an interview in Resident #9's room on 5/10/11 at 3:55 PM, Nurse #9 was asked if she was able to find the prealbumin lab results. Nurse #9 stated, "No, I couldn't find the lab results."</p>	F 502	<p>F502</p> <p>The facility will provide or obtain laboratory services to meet the needs of its residents.</p> <ol style="list-style-type: none"> 1. <ul style="list-style-type: none"> • Resident #9 – No adverse effect noted to resident. Order clarification received from Physician on 5/10/11 to complete prealbumin lab as ordered. • Resident #22 – No adverse effect noted to resident. Order clarification received from Physician on 5/13/11 to d/c order. 2. All residents with laboratory service orders have the potential to be affected by this alleged deficient practice. 3. DON, ADON, or designee to re-educate staff by 6/8/11 on lab protocol, lab easy program, and tracking on results to ensure compliance of laboratory services are maintained according to physician orders. DON, ADON, and designee from Gamma Laboratory services to conduct a lab audit 	06/08/2011

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445718	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2011
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NAME OF PROVIDER OR SUPPLIER ASHTON PLACE HEALTH & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3030 WALNUT GROVE RD MEMPHIS, TN 38111
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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 502	<p>Continued From page 40</p> <p>2. Medical record review for Resident #22 documented an admission date of 8/12/10 with diagnoses of Encephalopathy, End Stage Renal Disease, Cerebrovascular Accident and Osteoporosis. Review of a physician's order dated 5/4/11 documented, "...LIPID PROFILE & [and] VIT [Vitamin] D EVERY 6 MONTHS..." The facility was not able to provide documentation that Hospice had discontinued the lab orders.</p> <p>During an interview on A wing nurse's station on 5/11/11 at 12:45 PM, Nurse #16 stated, "Residents on Hospice, the facility doesn't draw labs unless previous order and deficiency in lab results. Hospice dc's [discontinues] lab orders."</p>	F 502	<p>to ensure no further concerns noted. DON, ADON, or designee to audit lab notebooks at a minimum of at least weekly for the next 8 weeks to ensure compliance of such.</p> <p>4. DON, ADON, or designee to report findings of above audits to the QA committee monthly for the next 3 months for further recommendations and follow-up.</p>	
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