

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN6007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2010
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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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N 767	<p>1200-8-6-.06(9)(i) Basic Services</p> <p>(9) Food and Dietetic Services.</p> <p>(i) Food shall be protected from dust, flies, rodents, unnecessary handling, droplet infection, overhead leakage and other sources of contamination whether in storage or while being prepared and served and/or transported through hallways.</p> <p>This Rule is not met as evidenced by: Type C Pending Penalty #22</p> <p>Tennessee Code Annotated 68-11-9-804(c)22: Food shall be protected from dust, flies, rodents, unnecessary handling, droplet infection, overhead leakage and other sources of contamination, whether in storage or while being prepared and served and/or transported through hallways.</p> <p>This RULE is not met as evidenced by:</p> <p>Based on policy review, observation and interview, it was determined the facility failed to ensure food was prepared or stored under sanitary conditions as evidenced by dirty kitchen equipment; wet nesting of plates, glasses and trays; no covers over light fixtures to protect food from glass in case of breakage; an oscillating fan in the dish wash room; and peeling pipe covers over the rack holding clean trays.</p> <p>The findings included:</p> <p>1. Review of the facility's "Food Handling Guidelines" documented, "The "AM/PM COOK CLEANING SCHEDULE" documented, "...2.</p>	N 767	<p>Please refer to corresponding F-tag for Plan of Correction regarding deficiencies listed under licensure.</p>	
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Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
CEO/Administrator

(X6) DATE

3-15-10

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N 767	<p>Continued From page 1</p> <p>CLEAN & [and] SANITIZE STOVE & GRIDDLE AFTER EACH SHIFT..."</p> <p>2. Observations during the initial tour of the kitchen on 3/1/10 beginning at 9:35 AM, revealed the following:</p> <ul style="list-style-type: none"> a. Stove grease trap coated with dried food and grease. b. Meat slicer with meat particles on the lip of the guard. c. Grease in the water of one of the steam well pans. d. Toaster covered with greasy black and brown crumbs. <p>During an interview in the kitchen on 3/1/10 beginning at 9:35 AM, the Dietary Manager (DM) stated, "...They [kitchen staff] clean the stove area every 2 days... [Meat slicer] cleaned after each use... It [Steam well pan] shouldn't [have grease in the water]... We tried to get off [bread crumbs from the toaster] and it won't come clean..."</p> <p>3. Observations in the kitchen on 3/2/10 at 9:30 AM, revealed the following:</p> <ul style="list-style-type: none"> a. Glasses and trays wet nested. b. Plates stacked in the plate warmer wet nested. <p>4. Observations in the kitchen on 3/2/10 at 1:03 PM, revealed the following:</p> <ul style="list-style-type: none"> a. Fourteen (14) light fixtures, containing 2 florescent bulbs each, with no protective covers to protect food from glass particles in case of breakage. b. A wall mounted fan, turned on, and oscillating between the dirty dish wash area and the clean dish wash area. c. A peeling pipe cover with strings hanging down over the rack holding clean trays. 	N 767		

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N 769	<p>1200-8-6-.06(9)(j) Basic Services</p> <p>(9) Food and Dietetic Services.</p> <p>(j) Prepared foods shall be kept hot (140°F or above) or cold (45°F or less).</p> <p>This Rule is not met as evidenced by: Type C Pending Penalty #33</p> <p>Tennessee Code Annotated 68-11-804(c)33: Prepared foods shall be kept hot (one hundred forty degrees Fahrenheit (140 F) or above) or cold (forty-five degrees Fahrenheit (45 F) or lower). Appropriate equipment for temperature maintenance, such as hot and cold serving units or insulated containers, shall be used.</p> <p>The RULE is not met as evidenced by:</p> <p>Based on observation and interview, it was determined the facility failed to ensure hot food was prepared and stored at 140 degrees Fahrenheit (F) or above.</p> <p>The findings included:</p> <p>Observations in the kitchen on 3/2/10 at 11:55 AM, revealed the following hot food tray line temperatures:</p> <p>a. Mechanical chopped meat 130 degrees F. b. Pureed green beans 130 degrees F. Fifty three trays had been served with hot food at the wrong temperature.</p> <p>During an interview in the kitchen on 3/2/10 at 12:25 PM, the DM stated, "...We're fixing to [reheat food] now. I'm sorry. I was so upset, I forgot to tell them [dietary staff to reheat the food]..."</p>	N 769		

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N1142	Continued From page 3	N1142		
N1142	<p>1200-8-6-.11(2)(i) Rectods and Reports</p> <p>(2) Unusual events shall be reported by the facility to the Department of Health in a format designed by the Department within seven (7) business days of the date of the identification of the abuse of a patient or an unexpected occurrence of accident that results in death, life threatening or serious injury to a patient.</p> <p>(i) This does not preclude the department from using information obtained under these rules in a disciplinary action commenced against a facility, or from taking a disciplinary action against a facility. Nor does this preclude the department from sharing such information with any appropriate governmental agency charged by federal or state law with regulatory oversight of the facility. However, all such information must at all times be maintained as confidential and not available to the public. Failure to report an unusual event, submit a corrective action report, or comply with a plan of correction as required herein may be grounds for disciplinary action pursuant to T.C.A. §68-11-207. This Rule is not met as evidenced by: Type C Pending Penalty #23</p> <p>Tennessee Code Annotated 68-11-804(c)23: Incidents (such as a fire in the nursing home, burning of a patient, suspected abuse of a patient, or an unusual accident that causes injury to a patient) shall be recorded, investigated within the facility, and reported pursuant to T.C.A. 68-11-211.</p> <p>This RULE is not met as evidenced by:</p> <p>Based on policy review, medical record review, observation and interview, it was determined the</p>	N1142		

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N1142	<p>Continued From page 4</p> <p>facility failed to ensure that a thorough investigation was completed for an injury of unknown origin, and failed to report the injury to the state agency for 1 of 30 (Resident #12) sampled residents.</p> <p>The findings included:</p> <p>Review of the facility's "Abuse/ Neglect/ Mistreatment: Guidelines for Prevention/Identification/Investigation" documented "Policy... It is the policy of this facility that residents have the right to be free from abuse... If, however, an incident occurs that may be considered abuse/neglect/mistreatment, the management staff will complete an investigation and notify the appropriate regulatory agency, according to the state guidelines and timeframes (may not exceed a maximum of 5 days after notification of the incident/occurrence)... Identification... The facility will be proactive in identifying occurrences, patterns and/or trends that may constitute possible/potential abuse or neglect... Investigation... The facility will thoroughly investigate, under the direction of the CEO [Chief Executive Officer], all injuries of unknown origin... to determine if abuse or neglect was involved... If the investigation finds that there is probable abuse, neglect or misappropriation of resident property, the CEO or DNS [Director of Nursing Services] must notify the State Regulatory Agency within five (5) days... Reporting and Response to Alleged Incidents... Any complaint of, observation of, or suspicion of resident abuse, mistreatment or neglect is to be thoroughly investigated, documented and reported to the proper authorities... The nursing or administrative supervisor assumes responsibility for immediate notification of the DNS and the CEO... The CEO, or designee, shall</p>	N1142		
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N1142	Continued From page 5 take the following actions to assure that the investigation is conducted appropriately: A. If the incident has resulted in an injury or is suspected to be the result of a sexual assault, the resident should be transferred to the emergency department... C. An immediate investigation into the alleged incident, during the shift it occurred on is initiated as follows: 1. Interview the resident or other witnesses. 2. Interview the staff member implicated. Have the employee document their knowledge/version of the incident in a written narrative that is dated and signed. 3. Interview all staff on that unit. Interview staff witnesses or other available witnesses. Witnesses are to document their knowledge of the incident in a written narrative, signed and dated. The CEO, or designee, will contact the State Regulatory Office and notify them of all the information present at that time. The Federal Regulations state that the facility has five (5) days to notify the State Regulatory Agency, but must follow the state guidelines on the time frames and complete the specific forms as required... Attachment A... Facility Investigation Guidelines and Forms... The purpose of this investigation is to address all types of abuse... 1. If the resident is injured, provide all the necessary medical treatment and stabilize his/her health... 2. If the resident is able, conduct an interview about the incident. The resident should be interviewed at least three (3) times... The purpose of three separate interviews is to determine if the story is consistent – DO NOT automatically discount a resident with dementia or other cognitive impairment. All staff on the unit at the time the incident occurred must be interviewed and a written statement is to be obtained... Witnesses to the Incident... 1. The Social Worker, CEO and/or the DNS should interview other potential residents (potential victims) within 24- [to] 48 hours of the alleged	N1142		

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N1142	Continued From page 6 incident... Nursing/Medical Staff 1. Interview anyone who treated the resident. 2. Ask them to prepare and sign a statement. Employees should be instructed to write a summary of the occurrence prior to the end of their shift. If they did not notice anything, they need to document that on the statement..." Medical record review for Resident #12 documented an admission date of 5/14/07 with diagnoses of Psychosis, Anemia, Alzheimer's Disease, Schizophrenia, Dementia, Congestive Heart Failure, Osteoarthritis, Osteoporosis and Peripheral Vascular Disease. Review of the most recent quarterly Minimum Data Set dated 12/2/09 documented the resident has long and short term memory problems, is moderately impaired with daily decision making skills, is totally dependent for all activities of daily living and for transfers, is non-ambulatory and is bedfast all or most of the time. Review of Resident #12's Care Plan dated 9/10/09 and reviewed on 12/10/09 documented "...Altered thought process with impaired cognition and communication as evidenced by problem understanding others as seen by short and long term memory problem and impaired decision making... Episodes of disorganized speech, easily distracted, and mental status varies throughout the course of the day...Bedfast..." Review of Resident #12's nurses' notes dated 9/17/09 documented "...At 840/A [8:40 AM] -- Noted raised area c [with] light bruising on Left side of forehead when CNA [Certified Nursing Assistant] bringing resident from shower. Res [resident] stated she bumped it this morning but couldn't remember on what. Res remained up in W/C [wheelchair] at 11AM [11:00 AM] noted swelling moving over & [and] down forehead Call	N1142		

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N1142	<p>Continued From page 7</p> <p>to [named nurse practitioner] notified and stated to get skull series..."</p> <p>Review of an incident report dated 9/17/09 documented the incident occurred at 7:40 AM in Resident #12's room. The report further documented "...Level of Consciousness: Alert -- Disoriented..." There was only one narrative stated attached to the incident report, written by the CNA, which stated that she (CNA) noticed the swelling after bringing the resident from the shower room. There were no other interviews documented with any other staff or residents.</p> <p>Observations in Resident #12's room on 3/1/10 at 9:45 AM and 3:15 PM and on 3/2/10 at 7:55 AM, revealed Resident #12 up in a gerichair at the bedside. Resident #12 was alert, confused and difficult to understand.</p> <p>During an interview in the conference room on 3/3/10 at 4:00 PM, the DNS was asked what should happen when an injury of unknown origin is identified. The DNS stated, "...the CNA would tell the charge nurse... the charge nurse should go to the room and do an assessment... and get a statement from the resident... if they [resident] can't tell them what happened... do an investigation..." The surveyor asked the DNS what she would do to investigate an incident. The DNS stated, "...I'd interview resident... staff members... roommate... check the MDS [Minimum Data Set]... talk to the charge nurse... anybody that might have seen her... every single shift prior to and the day of [the incident]..." The DNS was asked if this was an incident that should have been reported. The DNS stated, "...Yes Ma'am..." The DNS was then asked if this incident was reported. The DNS stated that she would check and see, then returned to the</p>	N1142		

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N1142	Continued From page 8 conference room at 4:25 PM, and stated "...No, Ma'am..."	N1142		