

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

PRINTED: 08/05/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445485	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2009
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RECEIVED

NAME OF PROVIDER OR SUPPLIER ALLENBROOKE NURSING AND REHABILITATION CENTER	STREET ADDRESS CITY, STATE, ZIP CODE 3933 ALLENBROOKE COVE MEMPHIS, TN 38118
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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 221 SS=D 483.13(a) PHYSICAL RESTRAINTS

The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

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 follow physician's orders or provide assessments for restraints for 2 of 14 (Residents #4 and 15) sampled residents with restraints.

The findings included:

- Review of the facility's "PHYSICIAN'S ORDER FOR A PHYSICAL RESTRAINT DEVICE" policy documented, "PROCEDURE: 1. Obtain a Physician's Order that includes the specific reason for restraint. ...3. The order must include a "release and reposition every two hours" 4. The order must state when the restraint is to be worn."

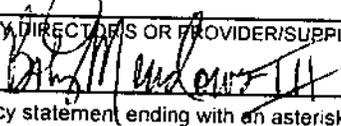
Review of the facility's "RESTRAINT/REDUCTION ASSESSMENT" policy documented, "...2. All residents using a restraint or psychoactive medication are to be evaluated and reevaluated approximately every quarter... 3. All residents who have evaluations which justify the use of restraints are to be using the least restrictive method possible as identified by the interdisciplinary team. 4. Residents who require the use of restraints or psychoactive medication are to have a care plan developed which outlines the methods and goals to reduce its use... 5. A specific physician's order is to be

F 221 Please consider this Plan of Correction as Allenbrooke Nursing and Rehabilitation, LLC credible allegation of compliance. This plan of correction constitutes a written allegation of substantial compliance under Federal Medicare & Medicaid requirements. Submission of this plan of correction is not an admission that a deficiency exist or that the facility agrees they were cited correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our residents and are submitted solely as a requirement of the provisions of Federal and State law. 9/14/09

RI #4 restraints were discontinued per physician's orders. RI#15 was re-assessed to ensure the appropriate restraint or device was utilized to ensure ongoing safety. Both residents were assessed and determined to be without adverse reaction. 9/14/09

All resident in restraints have the potential to be affected.

The Director of Nursing or Designee will re-in-service staff on the restraint reduction process and adherence to the interdisciplinary recommendations regarding restraint reduction.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 8/14/09
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any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This case report was faxed 8/14/09

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F 221 Continued From page 1
entered in the resident's Medical Record which details the reason, length of time to be used, type of restraint and when to be used..."

F 221

2. Medical record review for Resident #4 documented an admission date of 4/14/09 with diagnoses of End Stage Renal Disease, Diabetes Mellitus, Presenile Dementia and History of Infected Groin Wound. Review of the physician's recertification orders dated 7/7/09 documented, "BILATERAL HAND MITTENS TO PREVENT PULLING OUT VASC [vascular] CATH [catheter] & [and] SCRATCHING OPEN AREAS ON BODY."

Observations in Resident #4's room on 7/19/09 at 9:45 AM and 1:12 PM and on 7/20/09 at 8:42 AM, revealed Resident #4 did not have hand mittens on.

During an interview at the Central Nurses Station on 7/20/09 at 9:54 AM, Nurse #8 stated, "She [Resident #4] doesn't have mitten restraints."

3. Medical record review for Resident #15 documented an admission date of 4/23/09 with diagnoses of Pneumonitis, Hypertension, Alzheimer's, Dysphagia, and Depression.

Observations in the dining room on 7/19/09 at 1:20 PM and in Resident #15's room at on 7/19/09 at 3:15 PM, revealed Resident #15 sitting in her wheelchair (w/c) with a self release belt on.

Observations in Resident #15's room on 7/20/09 at 7:29 AM, revealed Resident #15 sitting in her w/c with a self release belt on.

During an interview in Resident #15's room on

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7/20/09 at 7:29 AM, Resident #15 was asked to release her seat belt. Resident #15 mumbled, "I will...", but she never made any effort to do so.

F 221

During an interview in Resident #15's room on 7/20/09 at 7:29 AM, Certified Nursing Assistant (CNA) #1 stated, "I've personally never seen her do it [release the seatbelt]..."

During an interview at the West Nurses' station on 7/21/09 at 7:30 AM, Nurse #10 stated, "...I've never seen her [Resident #15] get the restraint [self release belt] off..."

During an interview on the West hall at the nurses' station on 7/21/09, Nurse #12 stated, "She [Resident #15] was able to release her belt but after she had that orbital fracture, she has changed. I need to reassess her...I don't think she can do it [release the belt] now..."

F 278 483.20(g) - (j) RESIDENT ASSESSMENT
SS=D

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is

F 278

RI#2, #10, #8 MDS were corrected to reflect the resident's current restraint usage. Each resident was assessed and determined to be without adverse reactions.

9/14/09

All residents have the potential to be affected.

The Director of Nursing Services (DNS) or Designee will conduct re-inservicing to the MDS nursing staff on ensuring that the resident's assessment accurately, reflects the resident's status.

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F 278 Continued From page 3

subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observations, and interviews, it was determined the facility failed to complete the Minimum Data Set (MDS) to accurately assess each resident for the use of a restraint for 3 of 14 (Residents #2, 10 and 18) sampled residents with restraints.

The findings included:

1. Medical record review for Resident #2 documented an admission date of 7/13/07 with diagnoses of Alzheimer's Disease, Cerebral Vascular Accident, Senile Dementia and Seizure Disorder. Review of the "Physician's Telephone Orders" dated 1/21/08 documented, "Lap buddy when OOB [out of bed] to w/c [wheelchair] ck [check] q [every] 2 ° [hours] and Reposition due to Alzheimers & [and] Safety Awareness." The annual Minimum Data Set (MDS) dated 7/23/08 for Resident #2 documented in section P4 for "devices and restraints...chair prevents rising - 2. Used daily." Review of the "Restraint /Reduction Assessment" form dated 2/8/09 documented the following: "1. Type of restraint/psychoactive medication currently utilized: Lap Buddy." The

F 278

The DNS or Designee will conduct weekly MDS audits for 4 weeks, then monthly for 2 months to ensure MDS assessments correctly reflect the resident's restraint usage. Findings will be reported to the QA Committee for review monthly for 2 months and corrective action measures will be implemented as deemed necessary.

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F 278 Continued From page 4 F 278

quarterly MDS dated 4/14/09 documented in section P4 for "devices and restraints...chair prevents rising - 0. Not used." The annual MDS dated 7/14/09 documented in section P4 for "devices and restraints...chair prevents rising - 2. Used daily."

Observations in Resident #2's room on 7/19/09 at 9:52 AM, revealed Resident #2 sitting in her w/c with a lap buddy attached to the w/c. Continued observations on 7/19/09 at 3:12 PM, revealed Resident #2 sitting in the w/c with a lap buddy restraint in place, leaning forward/resting against the lap buddy.

Observations on the 200 hallway on 7/20/09 at 7:35 AM, revealed Resident #2 sitting in her w/c with the lap buddy attached to the w/c.

Observations in Resident #2's room on 7/20/09 at 12:55 PM and on 7/21/09 at 8:55 AM, revealed Resident #2 sitting in her w/c with the lap buddy attached to the w/c.

During an interview in the MDS Coordinator's office on 7/21/09 at 3:00 PM, Nurse #11 confirmed the quarterly MDS dated 4/14/09 for restraints was coded incorrectly.

2. Medical record review for Resident #10 documented an admission date of 2/20/09 with diagnoses of Alzheimer's Disease, Hypertension, and Atherosclerotic Heart Disease. The MDS dated 5/20/09 documented, "Section P4. Devices and Restraints e. chair prevents rising - 0. not used." The 5/20/09 MDS for restraints was coded incorrectly.

Observations in the Resident #10's room on

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7/19/09 at 9:20 AM, 1:20 PM and 4:20 PM, revealed Resident #10 seated in a w/c with a lap buddy in place constantly rocking back and forth with her whole body leaning forward each time.

F 278

Observations at the West nurse's station on 7/20/09 at 10:00 AM, revealed Resident #10 seated in a w/c with a lap buddy in place.

3. Medical record review for Resident #18 documented an admission date of 5/28/08 with diagnoses of Dementia, Osteoarthritis and Hypothyroidism. Review of the quarterly MDS dated 3/4/09 and the annual MDS dated 5/27/09 in section P4 for "Devices and Restraints" documented 0 defined as Not Used.

Observations in Resident #18's room on 7/19/09 at 9:30 AM, revealed Resident #18 sitting in a w/c with a lap tray attached.

Observations in the East Lounge on 7/20/09 at 5:24 PM, revealed Resident #18 in a w/c with a lap tray in place.

Observations in the East Lounge on 7/21/09 at 7:50 AM, revealed Resident #18 in a w/c leaning on the with a lap tray that was in place.

During an interview in the conference room on 7/21/09 at 10:42 AM, Nurse #2 verified the MDS was coded incorrect for restraints.

F 280 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS
SS=D

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or

F 280 RI #3 was careplanned for the 9 or more 9/14/09 meds. RI #4's careplan was reviewed by the IDT and careplan was updated to reflect the residents Current status. The IDT assessed RI #5 and the Careplan was updated to residents' current status. All residents were assessed with no adverse reaction

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F 280 Continued From page 6
changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on the medical record review, review of a diet card, observation and interview, it was determined the facility failed to revise the comprehensive care plan to reflect the use of nine or more medications, fluid restrictions or restraints for 3 of 26 (Residents #3, 4 and 5) sampled residents.

The findings included:

1. Medical record review for Resident #3 documented an admission date of 9/7/07 and readmission date of 3/21/09 with diagnoses of Diabetes Mellitus, Mental Status Change, Urinary Tract Infection, History of Breast Cancer, Sepsis, Pneumonia, Hypertension, Syncope, Collapse, and Alzheimer's Dementia. Review of the physician's orders dated 7/2/09 documented orders for the following 14 medications: Zinc

F 280 All residents have the potential to be affected.

The Director of Nursing Services or Designee will re-in-service staff on revising and updating the resident's care plan as determined by the resident's needs.

The Director of Nursing Services or Designee will randomly audit 5 residents' care plan weekly for 4 weeks, then 5 care plans monthly for 2 months to ensure the resident plan of care has been revised and updated to reflect the resident's assessed needs. Findings from the audits will be reported to the QA Committee for review and corrective action measures will be implemented as deemed necessary.

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Sulfate, Multivitamin, Alprazolam, Citalopram, Aspirin, Amlodipine, Bisacodyl, Vitamin C, Hydrocodone, Catapres TTS, Simvastatin, Seroquel, Lorazepam and Iron. Review of the care plan dated 6/22/09 did not reflect a care plan for nine or more medications.

During an interview in the West dining room on 7/19/09 at 3:00 PM, Nurse #11 stated, "It [care plan] was not done [reflect the use of 9 or more medications]. I did not capture it."

2. Medical record review for Resident #4 documented an admission date of 4/14/09 with diagnoses of End Stage Renal Disease, Diabetes Mellitus, Presenile Dementia and History of Infected Groin Wound. Review of the physician's telephone order dated 4/21/09 documented, "1000 cc [cubic centimeter] fluid restriction." Review of the care plan updated 7/14/09 documented, "Increase fluid consumption during day and limit fluid consumption during evening hours."

Review of the resident's diet card documented, "Notes: Fluid restriction. 4 oz [ounces] liquid at lunch."

Observations in Resident #4's room on 7/2/09 at 7:09 AM, revealed Resident #4 eating breakfast. The breakfast tray had 4 ounces of milk as the only fluids on the tray.

3. Medical record review for Resident #5 documented an admission date of 5/21/08 with diagnoses of Status Post Hip Fracture, Depression, Osteoarthritis, Anemia and Dementia. Review of the care plan dated 5/28/09 documented, "Apply restraint as ordered... Place

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F 280 Continued From page 8
resident in restraint-reduction program. Discuss necessity of restraining device for resident with resident/family. Use least restrictive device feasible trunk restraint." Review of the current physician's orders dated 7/7/09 did not document an order for a restraint. The care plan was not updated to reflect the restraint had been discontinued.

F 280

F 282 483.20(k)(3)(ii) COMPREHENSIVE CARE SS=D PLANS
During an interview in the East Unit Manager's office on 7/21/09 at 10:35 AM, Nurse #2 stated the resident was not in a restraint.

F 282

RI #15 was reviewed and assessed by the IDT and careplan was updated to reflect residents current needs and status. The resident was assessed with no adverse reaction 9/14/09

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

All residents have the potential to be affected.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, it was determined the facility failed to follow the care plan for a chair alarm for 1 of 26 (Resident #15) sampled residents with care plans.

The Director of Nursing Services or Designee will conduct re-in-servicing to the nursing staff on following the resident plan of care.

The findings included:

Medical record review for Resident #15 documented an admission date of 4/23/09 with a readmission date of 5/29/09 with diagnoses of Pneumonitis, Hypertension, Alzheimer's, Dysphagia, and Depression. Review of Resident #15's care plan dated 6/8/09 documented, "...Problem/Need ...Potential to fall due to impaired balance... Approaches... Use Low

The Director of Nursing or Designee will audit 5 residents' care plans weekly for 4 weeks, then monthly for 2 months to ensure the resident plan of care has been followed based on the resident's assessed needs. Findings will be reported to the QA Committee for review monthly for 2 months and corrective action measures will be implemented as deemed necessary.

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Bed...Chair/bed alarm..." F 282

Observations in Resident #15's room on 7/19/09 at 3:15 PM, on 7/20/09 at 7:35 AM, 10:15 AM, and 5:00 PM and on 7/21/09 at 7:40 AM, revealed Resident #15's bed was positioned at the regular height.

Observations in the dining room on 7/19/09 at 1:20 PM and in Resident #15's room at 3:15 PM, revealed Resident #15 sitting in the wheelchair (w/c) with no alarm present.

Observations in Resident #15's room on 7/20/09 at 7:29 AM and on 7/21/09 at 7:25 AM, revealed Resident #15 in a w/c with no alarm present.

During an interview at the West hall nurses' station on 7/21/09 at 7:30 AM, after viewing Resident #15's bed and Resident #15 sitting in her chair, Nurse #12 replied that the resident's bed was not a 'low bed' and stated, "...Yeah, she [Resident #15] should have the alarm transferred to the chair..."

F 312 483.25(a)(3) ACTIVITIES OF DAILY LIVING
SS=E

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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 residents dependent on staff or requiring staff assistance with activities of

F 312 RI#7, #1, #2, #3, #4, and #5 hair was combed and groomed as needed. 9/14/09

Resident #12 and #7 ear hair has been trimmed. Resident #6 facial and chin hair has been removed. RI#7, #1, #2, #3, #4, #5, #7, and #12 were assessed and determined to be without adverse affect.

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daily living (ADL) received the necessary services to maintain grooming for 2 of 23 (Residents #7 and 12) sampled residents and random residents (RRs #1, 2, 3, 4, 5, 6, and 7) observed.

The findings included:

1. Review of the facility's "A.M. CARE" policy documented, "...17. All residents hair will be combed & [and] brushed q [every] day & PRN [as needed]. 18. All residents will be free of facial hairs qd [daily]."

2. Medical record review for Resident #7 documented an admission date of 7/13/05 with a readmission date of 6/19/07 with diagnoses of Malaise and Fatigue, Late Effect Hemiplegia, Peripheral Vascular Disease, Hypertension, and Diabetes Mellitus. Review of the Minimum Data Set (MDS) dated 6/17/09 in section G for physical functioning and structural problems for personal hygiene was coded "3/3" indicating the resident required extensive assistance and two person physical assist with ADLs.

Observation in Resident #7's room on 7/19/09 at 9:50 AM and 1:20 PM, and on 7/21/09 at 8:35 AM, revealed Resident #7's hair was uncombed and frizzy.

Observations in the main dining room on 7/20/09 at 7:35 AM, revealed Resident #7's hair was uncombed.

3. Medical record review for Resident #12 documented an admission date of 1/14/09 with diagnoses of Dementia, Iron Deficiency, Hemiplegia and Dysphagia.

F 312

The Director of Nursing Services or Designee will conduct re-in-servicing to the clinical staff on carrying out activities of daily living in order to provide the necessary services to maintain appropriate grooming.

The Director of Nursing or Designee will complete 10 random ADL audits weekly for 4 weeks, then monthly for 2 months to ensure appropriate grooming has been provided. Findings will be reported to the QA Committee for review monthly for 2 months and corrective action measures will be implemented as deemed necessary.

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Observations during the initial tour of the facility on 7/19/09 at 9:05 AM revealed Resident #12 had long black hair growing out of his ears.

4. Medical record review for RR #1 documented an admission date of 2/14/05 with a readmission date of 7/19/06 with diagnoses of Delusional Disorders, Alzheimer's Disease, Hypertension, Anemia and Psychosis. Review of the MDS dated 6/1/09 in section G for physical functioning and structural problems for personal hygiene was coded "2/2" indicating the resident required limited assistance and one personal physical assist with ADLs.

Observations in the main dining room on 7/20/09 at 9:00 AM and 12:00 PM, revealed RR #1's hair was uncombed and frizzy.

Observation in RR #1's room on 7/20/09 at 5:05 PM, revealed RR #1's hair was still uncombed.

5. Medical record review for RR #2 documented an admission date of 6/11/07 with diagnoses of Hypothyroidism, Hyperlipidemia, Anorexia, Hypertension and Peripheral Vascular Disease. Review of the MDS dated 6/4/09 in section G for physical functioning and structural problems for personal hygiene was coded "3/2" indicating the resident required extensive assistance and one personal physical assist with ADLs.

Observations in RR #2's room on 7/20/09 at 9:00 AM and on 7/21/09 at 9:32 AM, revealed RR #2's hair was uncombed.

During an interview at the Central nurse's station on 7/21/09 at 9:30 AM, Nurse #2 stated, "Sometimes she [RR #2] resists care but not

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always, when she does they are to go back and try again later." Nurse #2 verified that RR #2's hair needed to be combed.

6. Medical record review for RR #3 documented an admission date of 11/21/08 with a readmission date of 1/24/09 with diagnoses of Presenile Dementia, Diabetes Mellitus, Hypertension, Renal Failure and Hyperlipidemia. Review of the MDS dated 5/18/09 in section G for physical functioning and structural problems for personal hygiene was coded "3" indicating the resident required extensive assistance with ADLs.

Observations in RR #3's room on 7/19/09 at 9:15 AM and 4:25 PM, revealed RR #3's hair was uncombed.

7. Medical record review for RR #4 documented an admission date of 4/28/08 with diagnoses of Late Effect Cerebral Vascular Disease, Hypertension and Chronic Ischemic Heart Disease. Review of the MDS dated 4/28/09 in section G for physical functioning and structural problems for personal hygiene was coded "2/1" indicating the resident required limited assistance with ADLs.

Observations in the main dining room on 7/20/09 at 7:40 AM and 12:00 PM, revealed RR #4's hair was uncombed and frizzy.

Observations in RR #4's room on 7/20/09 at 1:30 PM and 5:00 PM, revealed RR #4's remained uncombed and frizzy.

During an interview in RR #4's room on 7/20/09 at 1:30 PM, RR #4 stated, "The beautician did my hair. I can only do a little to it with my left hand."

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8. Medical record review for RR #5 documented an admission date of 6/11/07 with a readmission date of 12/12/07 with diagnoses of Hypothyroidism, Hyperlipidemia, Hypertension, Anorexia and Peripheral Vascular Disease. Review of the MDS dated 6/4/09 in section G for physical functioning and structural problems for personal hygiene was coded "3/2" indicating the resident required extensive assistance and two person physical assist with ADLs.

Observations in the main dining room on 7/20/09 at 12:30 PM, revealed RR #5's hair was uncombed.

9. Medical record review for RR #6 documented an admission date of 4/27/09 with diagnoses of Cellulitis of Leg, Hypertension, Peripheral Vascular Disease and Late Effect Cerebral Vascular Disease. Review of the MDS dated 5/4/09 in section G for physical functioning and structural problems for personal hygiene was coded "2/2" indicating the resident required limited assistance and one person physical assist with ADLs.

Observations in RR #6's room on 7/19/09 at 9:10 AM and on 7/21/09 at 9:20 AM, revealed RR #6 had numerous facial and chin hairs present.

10. Medical record review for RR #7 documented an admission date of 11/7/08 with diagnoses of Dementia, Congestive Heart Failure, Presenile Dementia, Diabetes Mellitus and Chronic Airway Obstruction. Review of the MDS dated 5/5/09 in section G for physical functioning and structural problems for personal hygiene was coded "1" indicating the resident required supervision with

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F 312 Continued From page 14
ADLs.

F 312

Observations in RR #7's room on 7/19/09 at 9:50 AM and on 7/21/09 at 10:30 AM, revealed RR #7 had numerous black hairs protruding from his ears.

11. During an interview at the Central nurse's station on 7/21/09 at 8:15 AM, Nurse #1 stated, "The CNAs [Certified Nursing Assistants] are responsible for combing their [referring to residents] hair when they get them dressed and throughout the day as needed. Nurses are responsible for seeing that residents are groomed everyday."

During an interview at the Central nurse's station on 7/21/09 at 8:45 AM, Nurse #1 stated, "The nurse or whoever she assigns can trim ear hairs."

During an interview at the East nurse's station on 7/21/09 at 9:15 AM, Nurse #2 stated, "The CNAs are responsible for grooming them [residents] and the nurses if the CNAs are tied up."

F 315 483.25(d) URINARY INCONTINENCE
SS=D

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.

This REQUIREMENT is not met as evidenced

F 315 RI#14 and RI#20 were provided corrective incontinent care. RI#14 and RI#20 were assessed and determined to be without adverse affects. C.N.A.#2 and the C.N.A that provided care for resident #20 were re-in-serviced on 7/21/2009.

9/14/09

All residents with Foley Catheter needing assistance with incontinent care have the potential to be affected.

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by:
Based on review of the "Tennessee CNA [Certified Nursing Assistant] Candidate Handbook Updated 01/15/2007", medical record review, observation and interview, it was determined the facility failed to ensure that peri-care was given correctly for 1 of 2 (Resident #14) sampled residents with indwelling catheter receiving peri-care. The facility failed to maintain the catheter tubing below the level of the bladder for 1 of 4 (Resident #20) sampled residents with indwelling catheters.

The findings included:

1. Review of the "Tennessee CNA Candidate Handbook Updated 01/15/2007" page 16 documented, "...11. Separates labia. 12. Using water and soapy washcloth, cleans one side of labia from top to bottom using a clean portion of a washcloth with each stroke..."

Medical record review for Resident #14 documented an admission date of 10/3/07 and a readmission date of 5/21/07 with diagnoses of Renal Failure, Paraplegia, Anemia, Neurogenic Bladder, Bi-Polar, Sigmoid Volvulus, Schizophrenia, and Hypertension.

Observations in Resident #14's room on 7/20/09 at 11:15 AM, revealed CNA #2 giving peri-care to Resident #14. CNA #2 held Resident #14's legs apart with one hand and then cleaned the perineal area with her other hand. CNA #2 made 3 strokes down the labia with three different wipes, but did not separate the labia before cleaning the area.

During an interview at the West nurses' station,

F 315 The Staff Development Coordinator or Designee will conduct re-in-service to the certified nursing assistants on providing incontinent care and on maintaining the Foley catheter bag below the resident's bladder.

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F 315	Continued From page 16 on 7/21/09 at 2:48 PM, Nurse #10 stated, "...Yes, you can't clean and spread the legs with one hand. She [CNA #2] needed help. I told her to take another person with her..." 2. Medical record review for Resident #20 documented an admission date of 11/19/07 with diagnoses of Senile Dementia, Dysphagia, Congestive Heart Failure, Late Effect Hemiplegia, Diabetes Mellitus and Hypertension. Observations in the East Hall Lounge during the breakfast meal on 7/20/09 at 7:38 AM, revealed Resident #20 in a geri chair with the Foley catheter tubing coming up the inside of the chair and over the armrest. The Foley catheter tubing was above the level of Resident #20's bladder.	F 315		
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS 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 policy review, medical record review, observation and interview, it was determined the facility failed to ensure 6 of 7 (Nurses #3, 4, 5, 6, 8 and 9) nurses administered medications with a medication error rate of less than 5 Percent (%) for sampled Residents #7, 8 and 27) and random residents (RR #8 and 9). A total of 11 medication errors were observed out of 44 opportunities for error, resulting in a medication error rate of 25%. The findings included: 1. Medical record review for RR #8 documented	F 332	RI #7, #8, & #27 and RR#8 and RR #9 were assessed and determined to be without adverse affects. Nurses #3, 4, 5, 6, 8, and 9 were re-in-serviced on medication administration. All residents have the potential to be affected. The Director of Nursing Services or Designee will conduct re-in-service to the licensed nurses on medication administration methods and techniques.	9/14/09

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an admission date 6/23/08 with diagnoses of late effects Hemiplegia-Dominant Extremity, Vascular Dementia, late effects Cardiovascular Disease-Cognitive effects and Hypertension. Review of the physician's orders dated 7/1/09 documented "...OYSTER CALCIUM W [with]/ VIT[Vitamin] D (1) TABLET VIA PEG [Percutaneous Endoscopic Gastrostomy] TUBE THREE TIMES DAILY..."

Observations on the West hall on 7/19/09 at 2:00 PM, revealed Nurse #3 crushed a tablet of coated Os Cal 500 D and removed the green coated shell with a tongue blade from the medicine cup and administered the Os-Cal to RR #8 by PEG. The failure to correctly administer the entire tablet resulted in medication error #1.

During an interview on the West hall with Nurse #3 on 7/19/09 at 2:02 PM, Nurse #3 stated, "I take the green coating out, it stops up the tubing."

2. Review of the facility's Eye Drop Administration Policy documented, "If multiple eye preparations are ordered, wait 3- [to] 5 minutes between administration times. For Azopt, Cosopt or Trusopt, wait 10 minutes between drops, per manufacture recommendation."

Medical record review for Resident #7 documented an admission date of 7/13/05 with diagnoses of late effects Hemiplegia-Non dominant Extremity, Difficulty in Walking, Congestive Heart Failure and Cerebrovascular Disease. Review of the physician's orders dated 7/1/09 documented "...TRUSOPT 2% EYE DROPS INSTILL ONE (1)DROP IN EACH EYE TWICE DAILY...ARTIFICIAL TEARS OPTH [ophthalmic] INSTILL (1) DROP IN EACH EYE

F 332
The Director of Nursing Services or Designee will conduct weekly medication pass observation for 4 weeks, then monthly for 2 months. Nurses failing medication pass observation will be re-in-serviced. Findings will be reported to the QA Committee for review monthly for 2 months and corrective action measures will be implemented as deemed necessary.

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FOUR TIMES DAILY...BRIMONIDINE 0.2% EYE DROPS INSTILL ONE (1) DROP IN EACH EYE TWICE DAILY..."

Observations in Resident #7's room on 7/19/09 at 4:25 PM, revealed Nurse #4 failed to administer Trusopt one drop to each eye as ordered by the physician. The failure to administer the Trusopt as ordered resulted in medication error #2.

Observations in Resident #7's room on 7/20/09 at 4:46 PM, revealed Nurse #6 administered Trusopt eye drops, one drop to each eye to Resident #7 and then administered Bronomidine eye drops, one drop to each eye at 4:53 PM, 7 minutes between the Trusopt and Bronomidine eye drops. Artificial tears were omitted from the medication administration. The failure to wait 10 minutes after administration of Trusopt and the omission of artificial tears one drop to both eyes resulted in medication errors #3 and #4.

3. Medical record review for Resident #27 documented an admission date of 7/10/08 with diagnoses of Osteoarthritis, Pressure Ulcer, Hypertension, and Rheumatoid Arthritis. Review of the physician's orders dated 7/709 documented, "...CALCIUM CARBONATE M [milligrams] (chewable) (1) TABLET BY MOUTH TWICE DAILY, COMBIVENT INHALER TWO (2) PUFFS FOUR TIMES DAILY..."

Observations in Resident #27's room on 7/20/09 at 12:00 PM, revealed Nurse #5 administered two puffs of the Combivent Inhaler to Resident #27 with a 20 second wait between puffs. The failure to wait one minute between puffs resulted in medication error #5.

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Observations in Resident #27's room on 7/20/09 at 4:50 PM, revealed Nurse #8 administered Calcium 600 mg with Vitamin D by mouth. The failure to administer the correct Calcium medication resulted in medication error #6. The resident self-administered the inhaler without instructions from the nurse with 10 seconds between first and second puffs. The failure to wait one minute between puffs resulted medication error #7.

4. Medical record review for RR #9 documented an admission date of 4/25/08, with diagnoses of late effects Cardiovascular Disease Non-dominant Extremity, late effect Cardiovascular Disease and Alzheimer's Disease. Review of the physician's orders dated 7/7/09 documented "...OYST-CAL-D 500 MG TABLET ONE (1) TABLET BY MOUTH TWICE DAILY..."

Observations in RR #9's room on 7/20/09 at 8:02 AM, revealed Nurse #9 administered Calcium-Oyster Shell 500 mg one tab by mouth. The failure to administer the Oyst-Cal-D as ordered by physician resulted in medication error #8.

5. Medical record review for Resident #8 documented an admission date of 12/10/07 with diagnoses of Osteoarthritis, Dehydration and Dysphasia. Review of the physician's orders dated 7/7/09 documented, "...Ferrous Sulfate 220 mg [milligrams] / [per] ml [milliliter] give 4 cc [centimeters] per peg tube daily, AMLODIPINE BESYLATE 5 MG TABLET VIA TUBE DAILY, NAMENDA 10 MG TABLET ONE (1) TABLET VIA TUBE TWICE DAILY, MORPHINE SULFATE 20 MG/ML SOLUTION 0.25 CC **5MG** UNDER TONGUE EVERY 2 HOURS..."

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Observations in RR #9's room, on 7/20/09 at 8:55 AM, revealed Nurse #9 measured 4 ml of Ferrous Sulfate in a plastic medication cup, then poured out a small amount. The failure to administer 4 ml of Ferrous Sulfate resulted in medication error #7. Nurse #9 administered Amlodipine 5 mg one tab by mouth and Namenda 10 mg one tab by mouth. The failure to administer Amlodipine and Namenda per peg resulted in medication errors #9 and #10. Morphine Sulfate 20 mg/ml 0.25 ml was omitted. The failure to administer Morphine Sulfate 20 mg/ml solution 0.25 ml sublingual resulted in medication error #11.

6. During interview in the office of the Director of Nursing (DON) with the DON and the Nurse Consultant on 7/21/09 at 12:50 PM, the DON and Nurse Consultant was informed of the medication error rate and errors identified. When the DON was asked if she had conducted any medication administration observations she stated, "Not since I've been here." When the Nurse Consultant was asked if she had conducted any medication administration observations, she stated, "...have done some but not very much."

F 372 483.35(i)(3) SANITARY CONDITIONS -
SS=D GARBAGE DISPOSAL

9/14/09

The facility must dispose of garbage and refuse properly.

This REQUIREMENT is not met as evidenced by:

Based on observations and interview, it was determined the facility failed to ensure dumpsters were covered and that garbage was properly contained in the dumpsters on 2 of 3 (7/19/09 and

F 372 The Dumpster contract was immediately changed and another dumpster was added along with 7 day delivery.

All residents have the potential to be affected.

The Executive Director or Designee will Re-Inservice staff are aware of proper garbage and refuse disposal.

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F 372 Continued From page 21
7/20/09) days of the annual survey.

The findings included:

1. Observations of the facility's two dumpsters on 7/19/09 at 8:45 AM, revealed the dumpsters were uncovered and white garbage bags were protruding from the dumpsters.

Observations of the facility's two dumpsters on 7/19/09 at 8:22 PM, revealed the dumpsters were overflowing with white garbage bags. There were two white bags on the ground in front of the dumpsters. The lids to the dumpsters were not closed and could not be closed due to overflowing of garbage which was stacked above the top of the dumpsters.

2. Observations of the facility's two dumpsters on 7/20/09 at 7:15 AM, revealed the dumpsters were overflowing with white garbage bags.

During an interview in the conference room on 7/21/09 at 1:45 PM, the Administrator stated, "The way the dumpsters were Sunday [7/19/09] isn't the way they usually are."

F 441 483.65(a) INFECTION CONTROL
SS=D

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

F 372

The Executive Director will check the dumpster Weekly for 2 months to ensure the dumpster is not out of compliance with regulation. Findings will be reported to the QA Committee for review and corrective action will be implemented if deemed necessary

F 441 The Nebulizer was cleaned prior to the 9/14/09

RI#27 next medication administration. LPN #8 was re-in-serviced on infection control practices related to cleaning of the Nebulizer after medication administration.

All residents with Nebulizer treatment have the potential to be affected.

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F 441 Continued From page 22

This REQUIREMENT is not met as evidenced by:
Based on policy review and observation, it was determined the facility failed to ensure that 1 of 7 (Nurse #8) nurses observed during the medication administration pass maintained infection control practices to prevent the possibility of cross contamination by failing to clean the nebulizer inhaler and aerochamber after use.

The findings included:

Review of the facility's oral inhalation administration policy and procedures documented, "...12. Take apart the inhaler and aerochamber and rinse and dry the inhaler mouthpiece and aero chamber..."

Observations in Resident #27's room on 7/20/09 at 4:50 PM, revealed Nurse #8 administered Xopenex 1.25 milligrams per 3 millimeters per nebulizer to the resident. Upon completion of the treatment the nurse wiped the mask with a tissue and replaced it in a plastic bag. Nurse #8 failed to follow the facility's policy and procedure for cleansing the aerochamber.

F 514 483.75(l)(1) CLINICAL RECORDS
SS=D

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the

F 441

The Staff Nurse Development or Designee will conduct re-in-service the licensed nurses on infection control practices related to cleaning Nebulizer after medication administration.

Staff Development Coordinator or designee will conduct weekly audits on 4 Licensed Nurses performing Nebulizer treatment for 4 weeks, then monthly for 2 months. Findings will be reported to the QA Committee for review monthly for 2 months and corrective action measures will be implemented as deemed necessary.

F 514 Resident #4, #8, and #9 medical records 9/14/09

have been corrected to reflect the correct route for medication administration.

Resident #15 medical records have been corrected to reflect the correct lab orders as ordered by the physician.

Resident #18 medical records have been

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F 514 Continued From page 23
resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation and interview, it was determined the facility failed to maintain accurate medical records for medication administration routes, laboratory tests and restraints for 5 of 26 (Residents #4, 8, 9, 15 and 18) sampled residents.

The findings included:

1. Medical record review for Resident #4 documented an admission date of 4/14/09 with diagnoses of End Stage Renal Disease, Diabetes Mellitus, Presenile Dementia and History of Infected Groin Wound. Review of a physician's telephone order dated 6/29/09 documented, "Discontinue peg [Percutaneous Endoscopic Gastrostomy] tube feeding per Dietician request. Resident currently on regular diet." Review of the Minimum Data Set dated as completed on 5/1/09 documented in section K6 (Parenteral or Enteral Intake) that Resident #4 did not receive PEG feedings. Review of Resident #4's current physician re-certification medications orders signed 7/7/09 documented, Plavix, Allopurinol, Ascorbic Acid, Gabapentin, Metoprolol, Amitiza, Clonidine, Sertraline, Sensipar, Ferrous Sulfate, Furosemide, Ranexa and Hydralazine by mouth and Cymbalta and Simvastatin by tube.

During an interview at the Central Hall Nurses Station on 7/20/09 at 9:54 AM, Nurse #8 stated,

F 514 corrected to reflect the appropriate restraint order.

All resident have the potential to be affected.

The Director of Nursing Services or Designee will conduct re-in-service to licensed nursing staff on maintaining accurate medical records for medication administration routes, laboratory tests, and restraints.

The Director of Nursing Services or Designee will weekly randomly audit of 10% of the resident's census to ensure that medication administration routes, laboratory tests, and restraints are accurately transcribed in the resident's medical records for 4 weeks, then monthly for two months. Findings will be reported to the QA Committee for review monthly for 2 months and corrective action measures will be implemented as deemed necessary.

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F 514	Continued From page 24 "She [Resident #4] gets all her meds [medications] by mouth, not tube."	F 514		
	<p>2. Medical record review for Resident #8 documented an admission date of 2/1/07 with a readmission date of 2/4/09 with diagnoses of Dementia, Psychosis, Dysphagia and Gastrostomy. Review of a physician's re-certification order dated 7/7/09 documented, "MAY CRUSH MEDS AND GIVE PER PEG TUBE." Review of the current re-certification medication orders signed 7/7/09 documented Zoloft, Restoril, Trazodone, Lortab, and Tylenol by mouth and Norvasc, Namenda, Aricept, Ativan, and Dulcolax by tube.</p> <p>During an interview at the East nurse's station on 7/21/09 at 9:12 AM, Nurse #2 stated, "She [Resident #8] can take them PO [by mouth] since she's eating now. She can take them either way [tube or by mouth]."</p>			
	<p>3. Medical record review for Resident #9 documented an admission date of 9/7/08 with a readmission date of 10/24/08 with diagnoses of Late Effect Cerebral Vascular Disease, Atrial Fibrillation, Congestive Heart Failure and Diabetes Mellitus. Review of a physician telephone order dated 5/18/09 documented, "...Removal of Peg tube on 5/20/09." Review of a re-certification order dated 7/7/09 documented, "...NEXIUM 40 MG [milligrams] ONE (1) PACKET MIXED WITH 15cc [cubic centimeters] H2O) [water] VIA TUBE TWICE DAILY."</p> <p>During an interview at the Central nurse's station on 7/21/09 at 8:10 AM, Nurse #1 stated, "He [Resident #9] doesn't have [PEG] tube anymore."</p>			

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F 514 Continued From page 25 F 514

4. Medical record review for Resident #15 documented an admission date of 4/23/09 and readmission date of 5/29/09 with diagnoses of Pneumonitis, Hypertension, Alzheimer's, Bi-Polar, and Dysphagia. Review of the physician's orders signed on 6/3/09 documented, "LAB ORDERS CBC [complete blood count] Q [every] 6 MONTHS CMP [complete metabolic profile] Q 6 MONTHS TSH [thyroid stimulating hormone] Q 6 MONTHS..." Review of the physician's orders signed on 7/7/09 documented no lab orders.

During an interview at the West nurses' station on 7/21/09 at 7:30 AM, Nurse #10 stated, "Yes, the labs should have been transferred to the next recert [re-certification] orders...Yes, she [Resident #15] should have the order [for labs]..."

5. Medical record review for Resident #18 documented an admission date of 5/28/08 with diagnoses of Dementia, Osteoarthritis and Hypothyroidism. Review of the current physician's re-certification orders dated 7/2/09 did not document the resident had a physical restraint.

Observations in Resident #18's room on 7/19/09 at 9:30 AM, revealed Resident #18 sitting in a wheelchair (w/c) with a lap tray in place.

Observations in the East Lounge on 7/20/09 at 5:24 PM, revealed Resident #18 in a w/c with a lap tray in place.

Observations in the East Lounge on 7/21/09 at 7:50 AM, revealed Resident #18 in a w/c leaning on a lap tray in place on the w/c.

During an interview in the conference room on 7/21/09 at 10:42 AM, Nurse #2 provided a

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F 514	Continued From page 26	F 514	physician's order dated 7/8/08 for a restraint and stated, "The order is for '08. We don't rewrite them."	
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F 514