

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN7940	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/21/2009
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NAME OF PROVIDER OR SUPPLIER  ALLENBROOKE NURSING AND REHABILITAT	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) COMPLETE DATE
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N 629 1200-8-6-.06(3)(b)8. Basic Services

N 629

(3) Infection Control.

8. Water pitchers, glasses, thermometers, emesis basins, douche apparatus, enema apparatus, urinals, mouthwash cups, bedpans and similar items of equipment coming into intimate contact with residents shall be disinfected or sterilized after each use unless individual equipment for each is provided and then sterilized or disinfected between residents and as often as necessary to maintain them in a clean and sanitary condition. Single use, resident disposable items are acceptable but shall not be reused.

This Rule is not met as evidenced by:  
Type C Pending Penalty #31

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

The Nebulizer was cleaned prior to the 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.

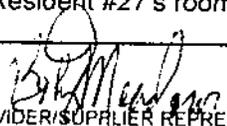
The Staff Nurse Development or Designee will conduct re-in-service the licensed nurses on infection control practices related to cleaning Nebulizer after medication administration.

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.

9/14/09

Division of Health Care Facilities

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



TITLE

*Administrative*

(X6) DATE

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N 629 Continued From page 1  
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.

N 629

N 700 1200-8-6-.06(4)(x) Basic Services  
(4) Nursing Services.  
  
(x) Restraints may be applied or administered to residents only on the signed order of a physician. The signed physician's order must be for a specified and limited period of time and must document the necessity of the restraint. There shall be no standing orders for restraints.

N 700

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.

This Rule is not met as evidenced by:  
Based on policy review, medical record review, observation and interview, it was determined that the facility failed to obtain a physician's order for a restraint for 1 of 14 (Resident #15) sampled residents with restraints.

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.

The findings included:  
  
Review of the facility's physician's order for 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."

Medical record review for Resident #15 documented an admission date of 4/23/09 with

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N 700 Continued From page 2 N 700

diagnoses of Pneumonitis, Hypertension, Alzheimer's, Dysphagia, and Depression. Review of the most recent physician's re-certification orders dated 7/7/09 revealed that there was no order for the use of a restraint.

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

Observations in the dining room on 7/19/09 at 3:15 PM, revealed Resident #15 sitting in her 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 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.

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 [Resident #15] 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... Yes, she should have an order [for the restraint]..."