

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

PRINTED: 08/24/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445133</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/19/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALLEN MORGAN HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>177 NORTH HIGHLAND MEMPHIS, TN 38111</b>	
(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 278 SS=D	<p><b>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</b></p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is 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.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to accurately assess residents for medications for 1 of 7 (Resident #9) sampled residents of the 14 residents included in the stage 2 review.</p>	F 278	<p>Resident #9 was reassessed and Minimum Data Set was corrected to appropriately reflect resident's Buspar.</p>	08/20/15

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

*Acceptable Poc 8/27/15 JP PHWUZ*  
*G. Komas Henken*

TITLE

*ADMINISTRATOR*

(X6) DATE

*8/27/15*

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

*This was faxed on 8/27/15 JP*

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F 278	Continued From page 1 The findings included:  Medical record review revealed Resident #9 was admitted to the facility on 6/23/15 with diagnoses of Cerebral Artery Occlusion, Traumatic Fracture of Vertebrae, Symbolic Dysfunction, Anxiety, Legal Blindness, Encephalopathy, Urinary Tract Infection, Dialystolic Heart Failure, Hypertension, and Macular Degeneration.  The physician's order dated 7/14/15 with a start date of 6/23/15 documented, "...Buspar 5 mg [milligrams] i [one] PO [by mouth] BID [twice per day]..."  The admission Minimum Data Set (MDS) with an assessment reference date of 6/30/15 did not reflect that Resident #9 received an antianxiety medication (Buspar).  Interview with Licensed Practical Nurse (LPN) #1 on 8/18/15 at 4:58 PM, in the conference room, LPN #1 was asked if Buspar should have been on Resident #9's admission MDS. LPN #1 stated, "Yes."	F 278	9 out of 9 charts reviewed to ensure that all residents receiving antianxiety medications are appropriately assessed and coded on the Minimum Data Set.  Polaris Group will in-service MDS nurses on appropriate assessment and coding of the Minimum Data Set. MDS Coordinator will review the current medication list with the charge nurse before submitting the Minimum Data Set.  DON and/or designee will monitor charts bi-weekly x4 weeks, then monthly x2, then PRN to ensure that those residents receiving antianxiety medications are appropriately coded on the Minimum Data Set. Findings will be reported to the QA meeting monthly x2, then PRN thereafter for review.	08/20/15	09/19/15
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT 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	F 441			

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F 441	<p>Continued From page 2 in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observation, and interview, the facility failed to ensure 1 of 3 (Registered Nurse (RN) #1) nurses followed practices to prevent the spread of infection and cross contamination during medication administration.</p> <p>The findings included:</p> <p>The facility's "Handwashing/Hand Hygiene" policy</p>	F 441			

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F 441	<p>Continued From page 3</p> <p>documented, "...Policy Statement... hand hygiene the primary means to prevent the spread of infections... Policy Interpretation and Implementation... 6. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60- [to] 95% [percent] ethanol or isopropanol for all the following situations... 6... a. Before and after direct contact with residents... j. After removing gloves..."</p> <p>Observations in Resident #42's room on 8/18/15 at 5:10 PM, revealed RN #1 washed her hands and applied gloves, administered 1 eyedrop into Resident #42's right eye, removed her gloves, and failed to perform hand hygiene, applied new gloves, and administered 1 eyedrop into Resident #42's left eye.</p> <p>Interview with the Director of Nursing (DON) on 8/19/15 at 9:40 AM, in the conference room, the DON was asked what should staff do between changing gloves. The DON stated, "Should wash hands."</p>	F 441	<p>RN was in-serviced on appropriate hand hygiene during administration of eye drops and between the application of new gloves.</p> <p>All nurses have the potential to be affected by the deficient practice.</p> <p>QA nurse and/or designee will in-service nurses on appropriate hand hygiene during administration of eye drops and between the application of new gloves.</p> <p>QA nurse and /or designee will monitor the nurses daily x2 weeks, weekly x2 weeks, then monthly x2, then PRN thereafter to ensure that appropriate hand hygiene is being done between the use of gloves.</p> <p>Findings will be reported to the QA meetings monthly x2, then PRN thereafter for review.</p>	09/19/15	

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