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FORM APPROVED
OMB NO. 0938-0391

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

SEP 23 2010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445133	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2010
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NAME OF PROVIDER OR SUPPLIER ALLEN MORGAN HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 177 NORTH HIGHLAND MEMPHIS, TN 38111
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F 241 SS=E	<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 observations, it was determined the facility failed to ensure 4 of 5 staff members (Nurse #1, Speech Therapist (ST) #1, Certified Nursing Assistant (CNA) #1 and Rehabilitation Technician (RT) #1) enhanced the dignity and respect of residents by not knocking on the resident's doors or gaining permission prior to entering the residents' rooms.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Review of the facility's "Resident's Rights Protocol" policy documented "...1. Knock and gain permission before entering the resident's room..." Observations in Resident #7's room on 9/7/10 at 11:14 AM, RT #1 entered Resident #7's room without knocking or gaining permission to enter. Observations during the breakfast tray pass on the skilled-unit on 9/8/10 beginning at 8:12 AM, CNA #1 entered resident rooms 136, 137, 138 and 139 without knocking or gaining permission to enter. Observations during the lunch tray pass on the skilled unit on 9/8/10 at 12:45 PM, ST #1 entered room 138 without knocking or gaining permission to enter. 	F 241	<p>The Plan of Correction constitutes My written allegation of compliance For the deficiencies cited. However, Submission of this Plan of Correction Is not an admission that a deficiency Exists or that one was cited correctly. This Plan of Correction is submitted To meet requirements established By the state and federal law.</p> <p>F241</p> <p>The facility will 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> <ol style="list-style-type: none"> Resident #7 discharged home on 09/09/10. Residents in rooms 136,137,138,139, and 143 provided with another copy of resident's rights explaining the right to privacy and dignity. All residents have the potential to be affected by the deficient practice. In-service staff on the definition of dignity and on maintaining the dignity of residents by knocking on doors before entering and requesting permission to enter. Audits will be done daily on units x 4 weeks, then weekly x 4, then monthly x2 and PRN thereafter by department heads to monitor employee interactions with residents including knocking on doors and requesting permission to enter. 	10/09/10
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *J. Thomas Hanlon* TITLE *FLOMIN.* (X6) DATE *9/22/10*

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 278	<p>Continued From page 2</p> <p>Based on medical record review, observation and interview, it was determined the facility failed to accurately assess residents for a fall or the presence of an indwelling Foley catheter for 2 of 8 (Residents #2 and 3) sampled residents.</p> <p>The findings included:</p> <p>1. Medical record review for Resident #2 documented an admission date of 7/13/09 with a readmission date of 8/13/10 with diagnoses of Psychosis, Congestive Heart Failure, Atrial Fibrillation, Dementia and Coronary Artery Disease. Review of the initial Minimum Data Set (MDS) dated 8/17/10 documented that Resident #2 had no falls in the past 30 to 180 days. Review of the admission evaluation and interim care plan documented Resident #2's most recent fall was on 8/6/10.</p> <p>During an interview in Room 145 on 9/9/10 at 12:30 PM, the Director of Nursing (DON) was asked about Resident #2's MDS not documenting falls. The DON stated, "I just made an error, he [Resident #2] had falls..."</p> <p>2. Medical record review for Resident #3 documented an admission date of 8/23/10 with diagnoses of Hypertension, Urinary Tract Infection, Diabetes Mellitus, Hyperlipidemia, Hypothyroidism, Spinal Cord Paralysis, Dementia and Neurogenic Bladder. Review of the physician's admission orders dated 8/24/10 documented "...Foley Catheter care q [every] shift per facility protocol... Change Foley catheter monthly..." Review of the initial MDS dated 9/4/10 did not reflect that Resident #3 had an indwelling catheter.</p>	F 278	<p>3) Interdisciplinary team will review new admissions and plan of care for those residents to ensure issues are addressed and identified on the MDS assessment.</p> <p>4) Director of Nursing and/or designee will review 20% of resident assessments done weekly x 4 the monthly x 2 and PRN thereafter to ensure accuracy of MDS assessment. Findings will be reported to the QA & A Committee x 2 months then PRN thereafter.</p>	

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F 278	Continued From page 3 Observations in Resident #3's room on 9/7/10 at 10:45 AM and 3:15 PM and on 9/8/10 at 8:29 AM, 12:05 PM and 1:05 PM, revealed Resident #3 with a Foley catheter draining to a bedside privacy bag.	F 278	F309	10/09/10
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 and interview, it was determined the facility failed to ensure a physician's order for obtaining a pulse prior to administration of Coreg was followed for 1 of 8 (Resident #2) sampled residents.</p> <p>The findings included:</p> <p>Medical record review for Resident #2 documented an admission date of 7/13/09 with a readmission date of 8/13/10 with diagnoses of Psychosis, Congestive Heart Failure, Atrial Fibrillation, Dementia and Coronary Artery Disease. A physician's order dated 8/13/10 documented, "...Check pulse before administration of coreg... Hold Coreg for pulse < [less than] 55 and notify MD [Medical Doctor]..." Review of the Medication Administration Record (MAR) for August 2010 documented "...Coreg 6.25 mg [milligrams] p.o [by mouth] BID [twice a</p>	F 309	<p>Each resident will receive and the facility will 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>1)Order for pulse rate obtained and followed for resident #2. 2)Current orders will be reviewed to identify those residents on cardiac dysrhythmia medications who have the potential to be affected by the deficient practice. 3)New admission and readmission charts will be reviewed per IDT on an ongoing basis to ensure that cardiac medications requiring vital signs and/or parameters are identified and that orders are received and implemented for indicated monitoring. 4)Director of Nursing and/or designee will audit 20% of new admissions or readmissions to ensure that monitoring and parameters of cardiac drugs are in place weekly x 4, then monthly x2 and PRN thereafter. Findings will be reported to the QA & A Committee monthly x 2 then PRN thereafter.</p>	10/09/10

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F 309	Continued From page 4 day]..." There was no documentation that Resident #2's pulse had been taken prior to the administration of the Coreg.	F 309		
F 441 SS=E	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 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	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)Resident #1 and #2 will be monitored for any development of new infection and signs and symptoms will be reported to the physician for recommended treatment. 2)All residents have the potential to be affected by the deficient practice. 3)In-service will be given to staff members on hand washing, infection control, and tray delivery. Tray delivery and hand-washing after removal of gloves status post wound care will be monitored per QA nurse and/or designee 2 x weekly x 4 weeks, then monthly x 2 months, then PRN there-after. 4)DON and/or designee will review audits to ensure appropriate hand washing is observed and appropriate interventions are taken for non-compliance. Findings will be reported to QA & A Committee monthly x 2 then PRN thereafter.	10/09/10

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F 441	<p>Continued From page 5</p> <p>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 and observations, it was determined the facility failed to ensure 2 of 5 staff members (Nurse #1 and Nurse #2) washed their hands after removing gloves or between resident contacts during dining observations and a dressing change.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility's "Using Gloves" policy documented, "...Wash hands after removing gloves..." 2. Observations during a dressing change in Resident #1's room on 9/8/10 beginning at 11:30 AM, Nurse #1 donned a pair of gloves and cut off the soiled dressing. Nurse #1 used alcohol sanitizing hand gel and donned another pair of gloves. After cleaning the wound with wound cleanser, Nurse #1 removed her gloves, used sanitizing hand gel and donned another pair of gloves. Nurse #1 was not observed to wash her hands after removing her gloves. 3. Observations in the dining room on 9/8/10 beginning at 12:55 PM, Nurse #2 tied a bib around Random Resident (RR) #1's neck. Nurse 	F 441		
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F 441	Continued From page 6 #2 did not wash her hands before contact with RR #1. Without washing her hands, Nurse #2 picked up a visitor's tray at the same table, and served it to Resident #2's wife. Nurse #2 then picked up the Resident #2's straw from the tray, removed the paper wrapping with her bare hands, and with her bare fingers placed the straw into Resident #2's milk container. Nurse #2 did not wash her hands before or after contact with the residents.	F 441		