

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 000	<p>INITIAL COMMENTS</p> <p>On 9/10/12 through 9/20/12 an annual re-certification survey was completed. There were two complaints investigated during the annual survey. Complaint #TN00030017 was investigated with a deficiency cited at F314 J. Complaint #TN00030419 was investigated with deficiencies cited at F241 G, F253 F, F254 F, F312 D, F323 K and F353 L.</p> <p>The facility was cited with an Immediate Jeopardy (IJ) at F353, F354, 490, F493, F501, and 520 at scope and severity of "L". The facility's failure to provide sufficient and competent nursing staff and a registered nurse for at least 8 consecutive hours a day, 7 days a week; provide effective administration; provide a governing body to function to establish and implement policies regarding the management and operation of the facility; provide a medical director whose role is to coordinate facility-wide medical care; and failure to maintain an effective Quality Assurance and Assessment Committee placed the facility in IJ for all of the 97 resident residing in the facility.</p> <p>The facility was cited with an IJ at F223, F225, F226 and F323 at scope and severity of "K" and F224 at scope and severity of "J". The facility's failure to protect residents from verbal, physical, and mental abuse and failure to follow the facility policy of thoroughly investigating and reporting allegations of abuse placed Residents #14, 23, 47, 68, 81, 82 and 116 at an IJ. The facility's failure to ensure an environment free of accident hazards related to side rails, falls and access to unattended, closed units in the facility resulted in IJ.</p>	F 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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 000	<p>Continued From page 1</p> <p>The facility was cited with IJ at F157, F309, F502 and F505 at a scope and severity of "J". The facility's failure to follow physician's orders, obtain laboratory testing, and promptly notify the physician of the abnormal laboratory results and maintain the dignity of the resident placed Residents #23, 81 and 82 at an IJ.</p> <p>The facility was cited with IJ at F250 and F319 at a scope and severity of "J". The facility's failure to provide appropriate treatment and services and medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident placed Resident #116 at an IJ.</p> <p>The facility was cited with IJ at F314 at a scope and severity of "J". The facility's failure to provide treatment and care to prevent pressure ulcers placed Residents #54, 74 and 82 at an IJ.</p> <p>An extended survey was completed on 9/20/12.</p> <p>An exit conference was conducted with the Administrator (Adm), Facility Consultant (FC), Vice President (VP) and the Nursing Supervisor (NS) on 9/20/12 at 6:15 PM. The Administrator, Vice President and Director of Nursing (DON) were informed of the IJ's identified at F323, F223, F224, F225 and F226 on 9/13/12 at 10:30 AM. The Adm and DON were informed of the IJ identified at F157, F309 and F502 on 9/14/12 at 1:20 PM. The Adm and DON were informed of the IJ at F314 on 9/14/12 at 4:55 PM. The Adm, FC, VP, and NS were informed of the IJ at F250, F319, F353, F354, F490, F493 and F501 on 9/20/12 at 6:00 PM.</p>	F 000			

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F 000	Continued From page 2 The facility provided surveyors with a written response on 9/14/12 at 5:30 PM for accident prevention; process for obtaining ordered laboratory tests; notification to Medical Doctor of critical laboratory test results; and abuse investigation process. This written response was determined to be unacceptable on 9/14/12. The IJ was considered present and ongoing at the time of exit. The facility was cited with IJ at F520 at a scope and severity of "L" following administrative review on 10/1/12. The facility was notified of this IJ on 10/3/12 per phone conversation on 10/3/12 at 8:45 AM and via fax on 10/3/12 at 9:31 AM.	F 000			
F 156 SS=D	The IJ was determined to have begun on 6/3/12. 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing	F 156			

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F 156	<p>Continued From page 3</p> <p>facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State</p>	F 156			

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F 156	<p>Continued From page 4</p> <p>ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was</p>	F 156			

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F 156	Continued From page 5 determined the facility failed to ensure that Advance Beneficiary Notices (ABN) were issued for 2 of 3 (Residents #94 and #124) sampled residents reviewed for Advance Beneficiary Notices. The findings included: 1. Review of Resident #94's record revealed Resident #94 was admitted on 3/28/12 and discharged from skilled therapy on 5/1/12. The facility was unable to provide documentation that an ABN was given. 2. Review of Residents #124's record revealed Resident #124 was admitted on 3/28/12 and discharged from skilled therapy on 4/12/12. The facility was unable to provide documentation that an ABN was given. 3. During an interview in the conference room on 9/19/12 at 3:16 PM, the Administrator was asked for ABN for Residents #94 and 124. The Administrator stated, "It is not what it ought to be, we did not have a biller until 8/1/12, we did not have forms. No, we did not issue the notices..." During an interview conducted in the conference room on 9/19/12 at 4:22 PM the staff member responsible for billing was asked for ABN's. The billing staff member stated, "No ABN's issued since I have been here [8/1/12], have not had but one skilled resident and he is not ready for discharge."	F 156			
F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident;	F 157			

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F 157	<p>Continued From page 6</p> <p>consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>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 notify the physician of toxic, critical and abnormal laboratory results; that a swallowing study was not obtained and/or weight</p>	F 157			

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F 157	<p>Continued From page 7</p> <p>loss for 4 of 38 (Residents #81, 23, 101 and 124) sampled residents reviewed of the 38 residents included in the stage 2 review. The failure of the facility to timely notify the physician of critical, toxic and abnormal laboratory results which placed Residents #81 and Resident #23 in immediate jeopardy (IJ). The Administrator and Director of Nursing were informed of this IJ identified on 9/14/12 at 1:20 PM. The facility provided surveyors with a written response on 9/14/12 at 5:30 PM, for notifying the physician of critical laboratory test results. This written response was determined to be unacceptable on 9/14/12. The IJ was considered present and ongoing at the time of exit.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility "LAB [laboratory] POLICY" documented, "...PURPOSE: To provide adequate interventions to maintain stable health conditions... D. The LPN [Licensed Practical Nurse] will review lab results and contact the Md [Medical Doctor]. The LPN will document in the nurse's note whom, when and what information provided to MD with notation of any orders... L. The MD is to be notified of all critical lab values immediately. M. If no response from MD in (1) hour, the Nursing Supervisor is to be called. If still no response the DON [Director of Nursing] is to be notified..." 2. Medical record review for Resident #81 documented an admission date of 6/15/07 and readmitted on 7/16/12 with diagnoses of Cerebral Vascular Accident, Hypertension, Vascular Dementia, Above the Knee Amputation, and Peripheral Vascular Disease. A physician's order 	F 157			

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F 157	<p>Continued From page 8</p> <p>dated 7/16/12 documented "Warfarin 3 mg [milligrams] QD [every day] and Warfarin 10mg QHS [every night]." A physician's order dated 7/26/12 documented "monthly PT/INR [prothrombin time and normalized international ratio]."</p> <p>The annual Minimum Data Set (MDS) dated 3/1/12 documented a Brief Interview Mental Status (BIMS) score of 7 (indicating the resident was moderately impaired in decision making skills), extensive total care with activity of daily living (ADL), no swallowing issues and not on anticoagulants. The quarterly MDS dated 8/16/12 documented a BIMS score of 5 (severely impaired), no swallowing issues and on daily anticoagulants. The care plan dated 3/30/11 and updated on 8/22/12 documented, "...Potential for bleeding related to anticoagulant therapy... 3. Obtain lab work as ordered by MD..."</p> <p>The July 2012 Medication Administration Record (MAR) documented Resident #81 received a total of Warfarin 13 mg daily from 7/16/12 to (-) 7/31/12. The August 2012 MAR documented Resident #81 received a total of Warfarin 13 mg daily from 8/1/12-8/31/12. The September 2012 MAR documented Resident #81 received Warfarin 13 mg daily from 9/1/12-9/13/12.</p> <p>During an interview in the conference room on 9/12/12 at 5:30 PM, the DON stated, "unable to find any PT/INR's since his return from the hospital [7/16/12]."</p> <p>The facility obtained a PT/INR on 9/13/12 after the surveyor had asked about PT/INR results.</p>	F 157			

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F 157	<p>Continued From page 9</p> <p>On 9/14/12 at 7:40 AM, Nurse #3 brought in the results of the PT/INR that was done on 9/13/12. The PT/INR lab results were abnormally high. The PT was 43.1 seconds (normal PT is 11.6-14.4 seconds) and the INR value was 4.98 (normal INR is 1.4 or less).</p> <p>During an interview in the conference room on 9/14/12 at 7:50 AM, the DON was asked what the procedure for notifying the physician was. The DON stated, "Staff are to call the physician and keep calling till [until] they get a response. If no response then they are to notify the supervisor or me. I got no call about this."</p> <p>During an interview conducted in the conference room on 9/14/12 at 8:00 AM, Nurse #4 stated, "I have talked with [named physician] it was reported late yesterday [9/13/12] and just got the lab values faxed back this morning from the lab. He [MD] ordered PT/INR every other day. I am going to draw another one today..."</p> <p>Review of a nurse's note dated 9/14/12 at 8:15 AM documented, "Called [named physician] R/E [related to] abnormal lab values. New order obtained, states he will be here this AM, PT/INR critical." There was no further documentation concerning the abnormal high lab result until a physician's order dated 9/14/12 at 8:15 AM documented, "Hold Coumadin for now, collect PT/INR every other day."</p> <p>During an interview in the administrative office on 9/14/12 at 11:00 AM, the Physician/Medical Director was asked about the abnormal high PT/INR. The attending Physician/Medical Director stated, "I got a message from my answering</p>	F 157			

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F 157	<p>Continued From page 10</p> <p>service about 7:00 PM yesterday [9/13/12]. I called back and no one picked up." The surveyor asked if not answering the phone happened often. The attending Physician/Medical Director stated, "Yes, that has happened before [not answering phone] but I know the nurses would contact me again if it was something serious or send patient to hospital. I saw the patient [Resident #81] this morning, ordered to hold coumadin and check PT/INR's until down to 3 then to restart Coumadin 10mg daily... I was not aware that Coumadin 13 mg was given daily since readmission... My therapeutic INR goal is 2-3 for this patient..."</p> <p>Further review of nurse's note dated 9/14/12 at 10:30 AM documented, "Attempted to drawn a PT/INR. Resident refused stating "no" and jerking his arm back, pt. [patient] is scheduled for MBS [modified barium swallow]."</p> <p>During an interview at the 1st McRee nurses' station on 9/15/12 at 8:05 AM, Nurse #4 stated, "No I did not document that I notified [named physician] that [named Resident #81] refused to let me draw the lab."</p> <p>Further review of physician's orders dated 8/17/12 documented, "MBS and speech eval [evaluation] due to coughing while eating." There was no documentation of the MBS being done until 9/14/12 with a MBS study that documented the following recommendations: 1 NPO [nothing by mouth], 2. Dysphagia tx [treatment] for focus on laryngeal elevation and closure... 3. Repeat MBS in 2-3 weeks."</p> <p>Observations in Resident #81's room on 9/18/12</p>	F 157			

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F 157	<p>Continued From page 11</p> <p>at 7:45 AM, revealed Resident #81 coughing while eating a pureed meal.</p> <p>During an interview in Resident #81's room on 9/18/12 at 7:45 AM, certified nursing assistant (CNA) #3 stated, "He [Resident #81] feeds himself. I come back and check on him and help if he needs it. I have noticed since he came back from the hospital [7/16/12] that he is coughing more with eating. I did tell the charge nurse about it."</p> <p>During an interview in the conference room on 9/18/12 at 6:00 PM, the Physician stated, "No, I was not aware that they did not get the swallow study until today [9/18/12]. He is now NPO, currently has IV's [intravenous] going for hydration, family is being contacted for a possible PEG [Percutaneous Endoscopy Gastrostomy Tube]. If they [family] refuse the PEG then hospice will be contacted. I am not sure how speech therapy works here, will check, if it works we can reverse the PEG."</p> <p>The facility failed to notify the physician that the monthly PT/INR labs were not obtained as ordered and once obtained failed to timely notify the physician of the abnormal high results. The facility failed to notify the physician that Resident #81 refused the repeat lab draw and that the MBS was not obtained as ordered which resulted in an IJ for Resident #81.</p> <p>3. Medical record review for Resident #23 documented an admission date of 1/29/99 with diagnoses of Subarachnoid Hemorrhage, Hemiplegia, Diabetes, Dementia, Hypertension and Seizure Disorder and a readmission date of</p>	F 157			

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

PRINTED: 10/08/2012
FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 157	<p>Continued From page 12</p> <p>9/10/12 with a new diagnosis of Dilantin Toxicity. Review of a physician's order dated 8/12/12 documented, "...Add Dilantin 100 mg in A.M.; continue 400 mg HS [hour of sleep]; check Dilantin levels in 2 wks [weeks]..." Review of a physician's order dated 9/2/12 documented, "...Dilantin level, CBC [Complete Blood Count], CMP [Complete Metabolic Profile], Urine C&S [Culture and Sensitivity]..." The facility was unable to provide documentation of lab results for the ordered Dilantin levels, CBC, CMP or Urine C&S.</p> <p>Review of a physician's order dated 9/5/12 documented, "...Send to [named hospital] ER [emergency room] for eval of head due to fall on concrete..."</p> <p>Review of the hospital history and physical dated 9/5/12 documented, "...Dilantin of 31.2, normal is 10-20... admitted to the hospital with diagnosis of Dilantin toxicity... Dilantin was put on hold..."</p> <p>Review of a physician's order dated 9/10/12 documented, "...Readmit to [name of facility] post Dilantin Toxicity..."</p> <p>During an interview in the conference room on 9/13/12 at 8:00 AM, Nurse #3 was asked about the missing Dilantin results. Nurse #3 stated, "...I called the lab today and they faxed a Dilantin level that was done on 8/30/12..." Nurse #3 was asked if the physician had been notified of the 8/30/12 Dilantin level. Nurse #3 stated, "...I don't know..."</p> <p>During an interview in the administrative office on 9/14/12 at 11:00 AM, the medical director was asked if the facility had notified him of the 28.8</p>	F 157			

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F 157	<p>Continued From page 13</p> <p>Dilantin level. The medical director stated, "...No, if I had known the levels were high, I would have decreased the Dilantin..."</p> <p>During an interview in the DON's office on 9/14/12 at 1:00 PM, the DON was asked about the failure to notify the physician of the elevated Dilantin level. The DON stated, "...we have been having problems with lab..."</p> <p>The facility's failure to obtain, monitor and report Dilantin levels as ordered resulted in IJ to Resident #23.</p> <p>4. Medical Record review for Resident #101 documented an admission date of 4/1/10 with diagnoses of Diabetes Mellitus, Subarachnoid Hemorrhage, Hemiplegia Left-sided Weakness, Convulsions, Cerebrovascular Accident, Schizophrenia, Hypotension, Status Post Pneumonia and Dysphagia. Review of the weight tracking record dated 9/14/11 documented the resident's weight was 195 pounds (lbs). Six months later on 3/24/12 the resident's weight was documented as 175 lbs. The loss of 20 lbs in 6 months is a significant weight loss of 10.26 percent (%). The nurses notes, physician's orders and physician progress notes from 9/20/11 to 4/15/12 do not address the 10.26% weight loss. There is no documentation that the MD was notified of the unplanned significant weight loss.</p> <p>5. Medical record review for Resident #124 documented an admission date of 3/23/12 with diagnoses of Atrial Fibrillation, Diabetes Mellitus, Bradycardia, Hypertension, Dementia, Agitation, Sexual Inappropriate Behavior, Alcohol Abuse, Muscle Weakness, Symbolic Dysfunction and</p>	F 157			

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F 157	Continued From page 14 Dysphagia Oropharyngeal Phase. Review of the weight tracking record dated 3/24/12 documented an admission weight of 200 lbs and a weight of 190 lbs on 4/20/12. The weight loss of 10 lbs in one month (5%) was an unplanned significant weight loss. The physician was not notified of the unplanned significant weight loss.	F 157			
F 159 SS=C	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds	F 159			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 159	<p>Continued From page 15 of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that residents with money that was managed by the facility had ready accessibility to their personal funds. The facility managed money of 93 of the 97 residents residing in the facility.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Observations of the resident banking office on 1st Magoffin on 9/17/12 at 10:00 AM, revealed two random residents accessing cash from the business office manager. The bank hours posted on the office door were Monday through Thursday from 9:30 AM to 10:30 AM and from 2:30 PM to 3:30 PM. 2. Observations of the resident banking office on 1st Magoffin on 9/20/12 at 10:00 AM, revealed 	F 159			

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F 159	Continued From page 16 the office was closed. During an interview in the conference room on 9/20/12 at 11:00 AM, the vice president of the facility was asked why the resident banking office was closed. The vice president stated, "...the business office manager is not here today..." The vice president was asked if anyone was available to assist the residents when the business office manager (BOM) was not there. The vice president stated, "No."	F 159			
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal	F 164			

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

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F 164	<p>Continued From page 17</p> <p>and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, and interview, it was determined the facility failed to ensure that private health information was protected for 2 of 38 (Residents #81 and 82) residents reviewed in the stage 2 review and failed to ensure Resident #60 was provided with full visual privacy.</p> <p>The findings included:</p> <p>1. Review of the facility's Health Insurance Portability and Accountability Act (HIPPA) policy documented, "...it is a law put in place and regulated by the federal government to protect a client's privacy and personal information... examples of information we need to protect and ensure confidentiality is used... age, social security number, diagnosis, financial info [information], insurance status, lab [laboratory] an test results... Upon admission the Responsible Party [RP] or Health Care Surrogate designates who can have assess to the resident's information... limit information given over the telephone..."</p>	F 164			

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F 164	<p>Continued From page 18</p> <p>2. Medical record review for Resident #81 documented an admission date of 6/15/07 and readmitted 7/16/12 with diagnoses of Cerebral Vascular Accident, Hypertension, Vascular Dementia, Above the Knee Amputation of left leg, and Peripheral Vascular Disease. Resident #81's sister in law was the responsible party on admission of 6/15/07.</p> <p>During a family member interview in the conference room on 9/11/12 at 10:30 AM, a family member of Resident #81 stated, "[Named admissions clerk #1] forged [named family member sister in law's] signature to get Responsible Party [RP] switched over to [named] a cousin. The sister in law was the RP on admission from the hospital but had moved to Detroit. When confronted [named admissions clerk #1] admitted to signing [named family member sister in law's] name to change the RP. Family reported they had not given permission to do this."</p> <p>During an interview in the administrative suite on 9/12/12 at 12:30 PM, admission Clerk #2 stated, "I told them [staff] they could not change RP without the original RP's permission." Admission clerk #2 was asked who changed the RP. Admission Clerk #2 stated, "It was [named admission clerk #1]." Admission clerk #2 was asked if admission clerk #1 was still employed. Admission Clerk #2 stated, "Yes, part time, on call for us."</p> <p>Review of Resident #81's face sheet, with no date, documented the RP as a named cousin. A review of the current face sheet updated on</p>	F 164			

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F 164	<p>Continued From page 19</p> <p>9/11/12 documented the RP as one of the named brothers.</p> <p>Review of Resident #81's HIPPA form documented, "...My Protected Health Information [PHI] may be disclosed to: and listed 2 [named] Brothers and 1 [named] Niece of Resident #81. This form was signed on 6/15/07 by the responsible party who was the resident's sister in law. The cousin's name was not included as someone who could receive information in regard to Resident #81.</p> <p>Further medical record review for Resident #81 revealed a "Consent for Restraint Use" that documented, "...The following alternative measures have been unsuccessfully tried prior to using this restraint: chair alert and lap buddy... I understand that [named Resident #81] may be at greater risk for falls and will risk the consequences of walking unassisted or of self-injury without the use of physical restraints... The type of restraint to be used is a soft belt applied when up in w/c [wheelchair]... I give [name of facility] permission to physically restrain [named Resident #81]... Verification of Notification... on Feb. [February] 18, 2009. A [named] friend of [named Resident #81] was contacted by telephone and the above information was read to him/her." This was signed by facility representatives. The facility violated HIPPA by sharing medical information to a friend instead of the approved family members.</p> <p>3. Observations outside the Minimum Data Set (MDS) on 9/19/112 at 10:32 AM, revealed the Registered Nurse, the Activities Coordinator, and Resident #82 discussing the resident's care</p>	F 164			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 164	Continued From page 20 during the care plan meeting with the door open and discussion heard in the hallway. During an interview in room 401 on 9/10/12 at 5:10 PM, Resident #82 was asked if the staff provided privacy when they work with you in such as changing your clothes, providing treatment, and discussing our health condition. Resident #82 stated, "No, they leave the door open." During an interview at the 1st McRee nurses' station on 9/19/12 at 3:30 PM, Nurse #4 was asked how should the facility ensure privacy is maintained during a care plan meeting. Nurse #4 stated, "...meet in a private room, have the door shut." Nurse #4 was asked if the door was shut during the care plan meeting for Resident #82 on 9/19/12. Nurse # 4 stated, "We had the door shut and then opened it. She [Resident #82] decided to stay longer so the door was open." 4. Review of the facility's "Resident's Rights" policy documented, "...Is treated with consideration, respect, and full recognition of his/her dignity and individuality, including privacy in treatment and in care for his personal needs..." Observations in room 414- bed 2 (1st McRee) on 9/10/12 at 10:40 AM, revealed Resident #60 in bed with no clothes on and only a sheet pulled across his thighs. The privacy curtain was pulled between the door and the bed but not pulled around the foot of the bed to ensure full visual privacy.	F 164			
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of	F 167			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 167	<p>Continued From page 21</p> <p>the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure survey results were readily accessible to the 97 residents residing in the facility and the public on all nine days of the survey.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Observations at the receptionist desk on 9/10/12 , 9/11/12, 9/12/12, 9/13/12, 9/14/12, 9/15/12, 9/17/12, 9/18/12, 9/19/12 and 9/20/12 at 8:00 AM, revealed a sign on the window at the receptionist desk that documented, "A COPY OF THE MOST RECENT SURVEY IS AVAILABLE FROM THE RECEPTIONIST." The receptionist was unable to provide survey results for review on any of these dates. Observations at the 1st floor Magoffin nurses station on 9/10/12 at 11:00 AM, revealed a sign posted on the glass that documented survey results were located in a drawer inside the nurses station. <p>During an interview at the 1st Magoffin nurses</p>	F 167			

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

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F 167	Continued From page 22 station on 9/10/12 at 11:00 AM, the Vice-President and Nurse #4 verified the survey results were not in the drawer at the nurses station.	F 167			
F 170 SS=C	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on interview, it was determined the facility failed to ensure mail was delivered to the 97 residents on Saturday's. The findings included: During an interview in the Resident Council President's room on 9/18/12 at 8:30 AM, the Resident Council President stated, "We do not get Saturday delivery of mail." During an interview in the conference room on 9/19/12 at 10:00 AM, the Patient Care Advocate stated, "Mail is delivered Monday through Friday to the Receptionist, she gives it to the Biller who separates business from resident mail, the resident mail is given to the Social Worker who delivers it to the residents. There is no receptionist here on Saturday's to accept the mail so the post office does not deliver mail here."	F 170			
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS	F 221			

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

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F 221	<p>Continued From page 23</p> <p>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.</p> <p>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 utilize restraints properly for 1 of 1 (Resident #23) sampled resident with a restraint in use of the 38 residents included in the stage 2 review.</p> <p>The findings included:</p> <p>Review of the facility's "Physical Restraints" policy documented, "...Physical Restraints include... lap buddies... when a physical restraint is deemed necessary... the least restrictive device will be used first... a pre-restraining assessment will be completed... a physician's order will be obtained prior to restraint application... informed consent from the legal designee or resident must be obtained..."</p> <p>Medical record review for Resident #23 documented an admission date of 1/29/99 with diagnoses of Subarachnoid Hemorrhage, Hemiplegia, Diabetes, Dementia, Hypertension and Seizure Disorder and a readmission date of 9/10/12.</p> <p>Nurses notes dated 9/11/12 documented, "...Resident [#23] returned from hospital on 9/10/12 and had fall in BR [bathroom] per staff. Counseled resident on asking for assist</p>	F 221			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
(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 221	Continued From page 24 [assistance] when transferring and going to BR. Later saw resident attempting to get out of a chair. Informed resident that we would try a lap buddy as a reminder to ask for assist to transfer..." The facility was unable to provide documentation that a pre-restraint assessment had been done; that a physician's order was obtained for the use of the lap buddy; that the responsible party was notified for the use of the lap buddy restraint or that the least restrictive device was used. Observations in the 1st Magoffin hallway on 9/12/12 at 2:00 PM, revealed Resident #23 in a wheelchair with a lap buddy restraint in place. During an interview in the administrative hallway on 9/12/12 at 3:00 PM, Nurse #3 was asked why Resident #23 was restrained without an evaluation, without physician orders being were obtained for the use of the lap buddy, why the responsible was not notified and ensure the less restrictive means of fall prevention were not attempted. Nurse #3 stated, " ...it [lap buddy] is not a restraint ...it is a reminder..."	F 221			
F 223 SS=K	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.	F 223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
(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 223	<p>Continued From page 25</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, review of suspected abuse investigation form, review of nursing schedules, time clock forms, medical record review, observation, and interview, it was determined the facility failed to ensure 6 of 38 (Residents #47, 81, 14, 68, 82 and 116) sampled residents included in the stage 2 review were free from physical, verbal, or resident to resident abuse. The facility's failure to ensure the residents were free from physical, verbal, or resident to resident abuse placed Residents #47, 81, 14, 68, 82 and 116 in immediate jeopardy (IJ) as evidenced by staff failing to report allegations to management and failing to protect residents from abuse. The Administrator, Vice President and Director of Nursing were informed of this IJ identified on 9/13/12 at 10:30 AM. The facility provided surveyors with a written response on 9/14/12 at 5:30 PM, for their abuse investigation process. This written response was determined to be unacceptable on 9/14/12. This IJ was considered present and ongoing at the time of exit.</p> <p>The findings included:</p> <p>1. Review of the facility's "ABUSE" policy documented..." It shall be the policy of Americare Health and Rehabilitation Center to ensure that all of its residents receive professional, humane, and compassionate medical and nursing care that is free from verbal, sexual and/or involuntary seclusion... 1. Verbal Abuse: Any use of oral, written or gestured language that includes derogatory terms to the resident, their families or is stated within hearing distances to describe a</p>	F 223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
(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 223	Continued From page 26 resident(s) regardless of their age, ability to comprehend or disability... 3. Physical Abuse: Behavior that includes, hitting slapping... Physical abuse may also included controlling behavior through corporal punishment... 6. Resident to Resident: Behavior between one resident to another that results in injury, pain, mental anguish or the deprivation of needed services... REPORTING THE INCIDENT: 1. Initially notify the Social Services personnel to intervene, and interview the resident(s) involved. 2. Notify the Director of Nursing [DON] and the Administrator of all reported alleged incidents of abuse... Management personnel shall assess, investigate and report all signs of suspect abuse... In the event that a possible incident of abuse has been reported, management personnel will conduct an investigation as follows: 1. Identify all parties involved... 2. Identify any witnesses's... 3. Conduct an immediate interview(s) of the persons involved in the alleged abuse and document... 4. Immediately provide a safe environment for the resident involved in the alleged incident... 5. If an employee is involved in the suspected abuse, the employee will be suspended with pay, pending completed investigation of the alleged incident... 6. If another resident is involved, after the investigation has been completed, the resident will be returned to their assigned room or nursing unit and a room change will be made, if needed..." 2. Medical record review for Resident #47 documented the resident admitted on 7/27/09 with diagnoses of Spina Bifida, Paraplegia, Anemia, Gastro Intestinal Hemorrhage, Major Depressive Disorder with Psychosis, Deep Vein Thrombosis and Hypertension. The annual	F 223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
(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 223	<p>Continued From page 27</p> <p>Minimum Data Set (MDS) dated 5/31/12 and the quarterly MDS dated 3/8/12 documented the resident with a cognitive score of 15 which indicated that she was cognitively intact with no psychosis or behavioral symptoms.</p> <p>A nurses note dated 6/3/12 documented, "Resident came to this nurse while I was passing meds [medications], stated she was outside sitting in mobile chair next to her friend... stated, CNA [certified nursing assistant #14] started arguing with her, they both got into an argument, the quarrel escalated to 1st Magoffin hall, she said CNA [#14] put her hand on resident forehead and the other [hand] on her throat, started choking her and slap her face. tiny scratch noted to lt. [left] side of face... will continue to monitor..."</p> <p>During an interview in Resident #47's room on 9/19/12 at 8:00 AM, Resident #47 stated, "Been here 3 years... Yes, a CNA she tried to choke me, her name is [named CNA #14], yes, she has continued to take care of me [since that incident], I told the nurse."</p> <p>During an interview in the conference room on 9/18/12 at 5:00 PM, the Administrator stated, "No, was not aware of this [allegation of abuse to Resident #47] until today. I have talked with the CNA involved [CNA #14] and she has been suspended [9/18/12] until the investigation completed. The facility was unable to provide documentation that the nurse protected the resident from further potential abuse by the staff member accused of abusing the resident, which place Resident #47 in IJ.</p> <p>3. Medical record review for Resident #81</p>	F 223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 223	<p>Continued From page 28</p> <p>documented the resident admitted on 6/15/07 and readmitted 7/16/12 with diagnoses of Cerebral Vascular Accident, Hypertension, Vascular Dementia, Above the Knee Amputation of left leg, and Peripheral Vascular Disease. The annual MDS dated 3/1/12 documented a cognitive score of 7 indicating he was severely impairment, no behavioral symptoms, no falls, no wounds, required extensive care with activities of daily living, had no swallowing issues and was not on anticoagulants. The quarterly MDS dated 8/16/12 documented a cognitive score of 5 indicating he was severely impairment, no behavioral symptoms, no falls, no wounds, no swallowing issues, and on daily anticoagulants.</p> <p>During an interview in the conference room on 9/11/12 at 10:30 AM, a family member of Resident #81 stated, "Nurse [named #10] on Saturday 9/8/12 ripped cover off of wound, wound bled and he [Nurse #10] wiped it, showing no compassion, [Nurse #10] got very loud and rude when asked to see his supervisor. [Nurse #10] said, "I'm black, that's why I'm loud." [Nurse #10] said he had 36 patients and was over this entire building, you are not the RP [responsible party] we cannot speak to ya'll..."</p> <p>During an interview in the conference room on 9/11/12 at 11:00 AM, the Administrator was informed of the wound of unknown origin noted on 8/25/12 and of the incident voiced by the family member that occurred on 9/8/12. The Administrator stated, "Will contact RP and get the process [investigation] started..."</p> <p>During an interview in the conference room on 9/13/12 at 11:30 AM, Nurse #10 was asked if he</p>	F 223			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
(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 223	<p>Continued From page 29</p> <p>had ever been accused or involved in a abuse investigation. Nurse #10 stated, "Yes, about a year ago was accused of an inappropriate statement to a resident, was suspended and after investigation, it was found okay and they brought me back. Then about 4 to 6 months ago a resident accused me of pulling a plug of her hair out. They [management] found she [Resident #81] had told a CNA she planned to get my job and had requested hair from the brush." Nurse #10 was asked about Resident #81's wound care. Nurse #10 stated, "The CNA [#2] told me about the area [8/25/12]. I assessed it, cleaned and dressed it. I notified the physician and put a note in book for wound nurse to evaluate it. I did not notify family of the wound. The wound was open and bleeding... I was the supervisor that day and the next day and reported it to [named Vice President] on Sunday [8/26/12]... as an injury of unknown origin..."</p> <p>During an interview in the conference room on 9/13/12 at 4:50 PM, the Vice President (VP) was asked if Resident #81's injury of the unknown origin had been reported to her. The VP stated, "No, do not recall any report of an injury."</p> <p>During an interview in 1st McRee nurses station on 9/14/12 at 7:15 AM, CNA #2 was asked about Resident #81's wound. CNA #2 stated, "Yes, I found [named Resident #81's] wound, I was giving him his bath on Saturday 8/25/12, I called for [named Nurse #10], he came and took care of it. I worked on 8/24/12 and it [wound] was not there. I told [named VP] about it on Sunday 8/26/12 and she told me she was going to let the doctor know about it."</p>	F 223			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
(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 223	<p>Continued From page 30</p> <p>Observations in Resident #81's room on 9/17/12 at 10:00 AM, Resident #81 looked at the surveyor, nodded his head but was non verbal. A dressing was noted on his left upper chest area. Nurse #1 removed the dressing that was dated 9/15/12 from the left upper chest area revealing a wound approximately 3 inches long, 1/2 inches wide with lower 1/2 of wound bed open red and raw and upper part of wound was pink.</p> <p>Review of the August 2012 and September 2012 nursing schedules which are completed by the VP and review of the time clock correction forms signed by the supervisor documented Nurse #10 worked the date of the incident 8/25/12, and on 8/26/12 the date that the incident was reported to the VP. The schedule and time clock forms revealed Nurse #10 worked 8/27/12, 8/28/12, 8/31/12, 9/1/12, 9/2/12, 9/4/12, 9/5/12, 9/6/12, 9/7/12, 9/10/12, 9/11/12, and 9/13/12. Nurse #10 continued to work and care for the resident after this alleged incident had been reported to the VP on 8/26/12.</p> <p>The facility staff failed to protect Resident #81 from potential abuse after the VP was notified of the injury of unknown origin on 8/26/12. On 9/11/12 the Administrator was informed of the 8/25/12 injury of unknown origin and the allegation of alleged abuse that occurred on 9/8/12.</p> <p>The facility failed to protect Resident #81 from potential abuse when Nurse #10 continued to work and care for Resident #81 after being accused of an alleged abuse incident on 9/8/12. Nurse #10 was not suspended from work until 9/14/12. The failure to protect residents from</p>	F 223			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
(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 223	<p>Continued From page 31</p> <p>potential abuse placed Resident #81 in IJ.</p> <p>4. Medical record review for Resident #14 documented an admission date 6/16/09 with diagnoses of Diabetes Mellitus, Hypertension, Status Post Cerebrovascular Accident (CVA), Obesity, Bipolar Disorder, Constipation and Schizoaffective Disorder - Bipolar Type. Review of the annual MDS dated 12/8/11 documented, Resident #14 cognitive status scored "15" indicating being very cognitively aware and totally dependent on staff for bathing and toileting and that resident is always incontinent. The quarterly MDS dated 8/15/12 documented, cognitive status scored "11" indicating being cognitively aware and totally dependent on staff for bathing and always incontinent.</p> <p>During an interview in Resident #14's room on 9/10/12 beginning at 5:30 PM, Resident #14 was asked do you ever feel afraid because of the way you or some other residents are treated. Resident #14 stated, "Yes." Resident #14 was asked have you ever been treated roughly by staff. Resident #14 stated, "Yes." Resident #14 was asked if it was reported to anyone. Resident #14 stated, "No, I did not report them because I don't know who is the head nurse..." Resident #14 was asked has staff yelled or been rude to you. Resident #14 stated, "Yes... I ask them [CNAs] to wash my feet and legs and they say turn over here... I will beat your butt... they pull my bed away from the wall [so can't reach call light] they tell me don't push that call light... no nurses have said this, only CNAs..."</p> <p>During an interview in Resident #14's room on 9/12/12 at 4:00 PM, Resident #14 was asked</p>	F 223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
(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 223	<p>Continued From page 32</p> <p>again if she had ever been treated roughly by staff. Resident #14 stated, "Yes... that girl said turn over here and act right, she held my feet to the bed and squeezed my toes together... this is the only rough treatment that I've had... they never wash your legs or feet... they only want to wash the upper part..." Resident #14 was asked do you want to report this to the Director of Nursing (DON). Resident #14 stated, "Yes, I'll talk to her..."</p> <p>During an interview in the Director of Nursing's (DON) office on 9/12/12 at 4:20 PM, the DON was notified of Resident #14's request to talk to her. The DON was asked if she was aware that Resident #14 was having some problems with a CNA. The DON stated, "...I didn't know... I will talk to her..."</p> <p>During an interview in Resident #14's room on 9/13/12 at 8:18 AM, Resident #14 was asked if the DON talked with her yesterday. Resident #14 stated, "Yes, she did..." Resident #14 was asked if she was comfortable with the DON's response. Resident #14 stated, "Yes."</p> <p>During an interview in the DON's office on 9/14/12 at 12:15 PM, the DON was asked if she had talked to Resident #14, when the investigation was started and the progress on Resident #14's allegation. The DON stated, "Yes, I talked to her yesterday [9/13/12]... the investigation was started on 9/13/12 at 1:50 PM, the employees who work over there all the time were taken into her room... she was unable to identify the employee... the investigation continues..."</p>	F 223			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
(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 223	<p>Continued From page 33</p> <p>During an interview in the conference room on 9/18/12 at 8:50 AM, Nurse #4 was asked where the facility had gotten with the investigation of the allegation. Nurse #4 stated, "...I was in on that, she [Resident #14] didn't identify anybody, I even took a couple of people from 1st Magoffin and she didn't identify anyone... the DON is not here and I don't know how far she had gotten with it [investigation]..."</p> <p>During an interview in the Administrator's office on 9/18/12 at 6:00 PM, the Administrator was asked about the status of the investigation for Resident #14's allegation of abuse by a CNA. The Administrator stated, "...I don't really know, but I will check on it and get back with you..."</p> <p>During an interview in the front office on 9/19/12 at 7:30 AM, the Administrator confirmed the facility knew of Resident #14's allegation of abuse prior to the beginning of the survey [9/10/12]. The Administrator stated, "...I knew about the allegation about [named Resident #14] from her son, he called me on 9/7 and I told [named DON] about it on 9/8... Yes, I knew about it..."</p> <p>The facility was unable to provide documentation of an investigation or an incident report for Resident #14's allegation of abuse.</p> <p>The facility failed to protect Resident #14 from verbal, mental and physical harm after being informed of the allegations of abuse on 9/7/12 and the failure to follow the facility's policy of reporting and/or investigating allegations of abuse resulted in Resident #14 being fearful and placed Resident #14 in IJ.</p>	F 223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
(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 223	<p>Continued From page 34</p> <p>5. Medical record review for Resident #68 documented an admission date of 1/22/10 with diagnoses of Cerebrovascular Accident, Renal Insufficiency, Hemiplegia, Hypertension, Musculoskeletal Disorder of the Neck, Diabetes Mellitus, Osteoarthritis, Gastroenteritis, Callosities, Degenerative Joint Disease, Hypocholesterolemia, Frequent Urination, and Epilepsy.</p> <p>Review of the complaint made by Resident #68 taken by the Director of Nursing (DON) and the Administrator dated 9/6/12 at approximately 2:00 PM documented, "[Resident #68] reported that on Monday, September 3, 2012, after breakfast and smoke break, he went to the office to check on his monthly check. [Nurse #10] was standing in the hallway pointing "Go back to 1st floor." Resident #68 stated he replied "I'm going to check on some business." [Nurse #10] replied, "No, you go back now." Resident #68 states that "[Nurse #10] grabbed the back of his chair, swung him around hastily and pushed him toward the elevator." Resident #68 stated that he felt light-headed. Since then he has been having severe pain in his neck but has not reported this [pain in his neck at time of incident] to anyone. He stated he has reported the incident to the Social Worker. After reporting the pain to his nurse, [Resident #68] was examined by the Medical Director on 9/7/12, regarding his complaint of pain. Noted "Getting better-cervical disc several years ago." No changes were made in his plan of care."</p> <p>Review of the nurses notes dated 9/5/12 at 2:55 PM documented, "...Resident [#68] c/o [complained of] neck pain... Placed name in</p>	F 223			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 223	<p>Continued From page 35 physician's book..."</p> <p>Review of a physician's note dated 9/7/12 documented, "...neck pain sev [several] days... Has H/O [history of] cervical disc surgery year ago..."</p> <p>Review of the facility's review of suspected abuse investigation form documented, "...EMPLOYEE [circled on the form] /WITNESS STATEMENT... Resident's Name (alleged victim): [Resident #68]... Employee [circled on the form] ...Name: [Nurse #10]..." All other information on the form was blank. Review of the "INVESTIGATION OF ALLEDGED [alleged]... Abuse... Pending..."</p> <p>Review of the September 2012 nursing schedules which are completed by the Vice President revealed Nurse #10 worked and continued to care for Resident #68 on 9/4/12, 9/5/12, 9/6/12, 9/7/12, 9/10/12, 9/11/12, and 9/13/12. Nurse #10 was not suspended from work until 9/14/12.</p> <p>Observations at the 1st Magoffin nurses station on 9/11/12 at 7:45 AM, revealed Nurse #10 standing at the medication cart.</p> <p>During an interview in Resident #68's room on 9/11/12 beginning at 9:30 AM, Resident #68 was asked a series of screening questions to determine if he was of a cognitive level so that he could be interviewed regarding the care and treatment he received at the facility. Resident #68 was determined to be interviewable. Resident #68 was asked, "Have you ever been treated roughly by staff?" Resident #68 replied, "...[Named nurse #10] handles residents roughly... about a month ago I went upstairs to check on my funds... it was</p>	F 223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 223	<p>Continued From page 36</p> <p>the first of the month... and [Nurse #10] immediately told me to go back to my room and [Nurse #10] began shoving me around... turned me around in my wheelchair and my neck hurt... told the Director of Nursing... she said she would talk to him [Nurse #10]..."</p> <p>During an interview in the Administrator's office on 9/12/12 at 5:26 PM, the Administrator was asked what usually happens when an allegation of abuse occurs. The Administrator stated, "...I try to get the investigation done in 5 days but I am not always faithful in this... if it is a caregiver they are reassigned even if it is to another area... then I get all the statements... and make a decision..." The Administrator was asked if staff members are suspended according to the facility policy. The Administrator stated, "Yes." The Administrator was asked why Nurse #10 was not suspended after the allegation made by Resident #68. The Administrator stated, "I don't think this is abuse..."</p> <p>During an interview in the conference room on 9/14/12 at 8:50 AM, the Administrator stated, "...We suspended [Nurse #10] this morning. We told the Vice president he is not to be scheduled to work until the investigation is complete. We are investigating and getting statements at present..."</p> <p>During an interview in the Administrator's office on 9/18/12 at 11:00 AM, the Administrator confirmed that the investigation was still on-going.</p> <p>The facility failed to recognize abuse and protect residents from verbal, mental and physical abuse which placed Resident #68 in IJ.</p>	F 223			

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F 223	<p>Continued From page 37</p> <p>6. Medical record review for Resident #82 documented an admission date of 1/5/11 with diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus Type I, Hypertension, Chronic Renal Disease, Bipolar Disorder, Hypothyroidism, Gout, Obesity, and Defiant Behavior. Review of the annual MDS dated 6/14/12 documented in section C for cognitive patterns that Resident #82 was scored as "15" indicating the resident was cognitively intact.</p> <p>Resident #82 reported the following allegations of abuse to the surveyor:</p> <p>a. During an interview in Resident #82's room 401 on 9/12/12 at 8:20 AM, Resident #82 was asked if she was treated with respect and dignity by the staff. Resident #82 stated, "Some days [named CNA #2] is in one of her moods. She [CNA #2] talks to me like a little child, like she is my parent. One day she came in here and said if I blow that horn again I'm going to send you out. She [CNA #2] tried to say I had a horn and was blowing it and acting out... She [CNA #2] said I was going to go back to [named hospital]... She [CNA #2] threatens me with that all the time and makes me afraid. I told the supervisor."</p> <p>During an interview at the McRee nurses station on 9/13/12 at 9:15 AM, Nurse #4 was asked if she received a report of an allegation of abuse involving CNA #2 talking to Resident #82 in a demeaning way and threatening to have her sent out." Nurse #4 stated, "I remember her [Resident #82] telling me that... said it was something about a horn that was blowing... said the aide told her she would be sent back to [named hospital]."</p>	F 223			

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F 223	<p>Continued From page 38</p> <p>Nurse #4 was asked if the incident was investigated. Nurse #4 stated, "I didn't investigate. I reported it to the Social Worker (SW). I never heard anything else about it."</p> <p>During an interview in the SW's office on 9/13/12 at 3:40 PM, the SW was asked if Resident #82's allegation of abuse was investigated. The SW stated, "I talked to [named Resident #82] about the incident... I didn't officially investigate. I guess that would [responsible for investigating] be [named Administrator]... She [Resident #82] told me she was upset..."</p> <p>b. During an interview in room 401 on 9/13/12 at 4:35 PM, Resident #82 stated, "[Named CNA #16] called me names... called me "devil" and said "you are no good." I reported to the head nurse [DON]. [Named CNA #16] was taken off my assignment."</p> <p>During an interview in the DON's office on 9/14/12 at 10:12 AM, the DON was asked if an allegation of abuse involving Resident #82 had been investigated. The DON stated, "I kind of remember her talking about [named CNA #16]... She may have said something about how he talked to her, but it would be because he is a male. He was moved from her assignment... She did not tell me anything that seemed abusive."</p> <p>During an interview in the Administrator's office on 9/14/12 at 12:25 PM, the Adm stated, "I do remember being told she [Resident #82] had a problem with [named CNA #16] and Resident #82 had expressed this to the DON. I don't know where it went from that. If she felt this was an allegation of abuse I would expect her tell me</p>	F 223			

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

PRINTED: 10/08/2012
FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 223	<p>Continued From page 39</p> <p>right away." The Adm was asked if the DON reported the allegation. The Adm stated, "No. She [DON] told me she was looking into something that happened, but she did not tell me of an abusive situation."</p> <p>During an interview in the Administrator's (Adm) office on 9/17/12 at 9:30 AM, the Adm was asked if he considered being called "devil" and telling a resident "you are no good" abusive. The Adm stated, "By all means, I would consider that verbal abuse." The Adm was asked if the allegation had been investigated and reported. The Adm stated, "I'll have to ask..."</p> <p>During an interview in the DON's office on 9/14/12 at 10:12 AM, the DON was asked what was the process for handling an allegation of abuse. The DON stated, "...It's usually their [employees] word against the resident and I cannot prove anything. If they told me directly the employee was verbally abusive or physically rough I would report that. It just depends on what the resident tells me... If they say they cursed me, said ugly names, handled rough I know that is abuse. I report it immediately to Adm so he can start his investigation. The Adm reports it to the state because he is the abuse coordinator."</p> <p>During an interview in the Administrator's office on 9/18/12 at 4:01 PM, the Adm was asked where he was in the investigation process related to the reported allegation of abuse by Resident #82 on 9/14/12. The Adm stated, "Not very far. I'll get on that in the morning unless you want it today."</p> <p>The facility was unable to provide documentation</p>	F 223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 223	<p>Continued From page 40</p> <p>of an incident report or an investigation of the allegations of abuse reported by Resident #82. The facility failed to recognize abuse and protect Resident #82 from verbal, physical and mental abuse which placed Resident #82 in IJ.</p> <p>7. Medical record review for Resident #116 documented an admission date of 9/8/11 with diagnoses of Alzheimer's Dementia, Aggressive Behaviors, Coronary Artery Disease, Diabetes Mellitus, Hypertension and Congestive Heart Failure. Review of the MDS with an assessment reference date (ARD) of 3/1/12 section E-Behaviors, E0200-Behavioral Symptoms-Presence and Frequency was coded as 1 indicating presence of physical behavioral symptoms directed toward others occurring 1 to 3 days. Section E0800-Rejection of Care-Presence and Frequency was coded as 2 indicating this behavior had occurred 4 to (-) 6 days, but less than daily. Review of the MDS with an ARD of 8/17/12 section E-Behaviors, E0800 Rejection of Care-Presence and Frequency was coded as 1 indicating this behavior occurred 1-3 days.</p> <p>Review of nurses notes documented the following:</p> <p>a. 2/4/12 - "...Resident very agitated and restless @ [at] dinner time towards staff and other residents. Resident refused to eat dinner, attempted to hit nurse and another resident... Aggressive @ times..."</p> <p>b. 3/20/12 - "...Aggressive towards other resident and staff..."</p> <p>c. 4/9/12 - "...confusion noted @ times with agitation..."</p> <p>d. 4/20/12 - "...Agitated @ times..."</p> <p>e. 9/5/12 - "...Resident hit another resident in the</p>	F 223			

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

PRINTED: 10/08/2012
FORM APPROVED
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F 223	Continued From page 41 hallway on the 1st floor. No injuries noted to either resident. Resident stated, "hell yeah I hit the motherfucker" Im [I'm] sick of that motherfucker stealing shit from everybody." I tried to knock his motherfucking ass out of the w.c. [wheelchair]." Explained to resident he can not hit other residents. Resident [#116] stated "I'm gonna beat his ass if he steals from me again... Social worker notified and here to speak with residents. MD [Medical Doctor] notified and no new orders noted..." Review of Resident #116's care plan dated 3/1/12 and 8/23/12 had no documented aggressive behaviors, social service referrals or mental health referrals. Review of the social service notes from January 2012 to September 2012 documented no aggressive behaviors or mental health referrals. The nursing behavior assessment dated 9/21/11 had no documented behavior issues. There were no other behavior assessments documented since 9/21/11. The facility failed to monitor and address Resident #116's aggressive behaviors which placed Resident #116 and other residents in IJ.	F 223			
F 224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATE The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 224			

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

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F 224	Continued From page 42 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 implement their written policy to ensure 1 of 38 (Resident #82) sampled resident included in the stage 2 review was not neglected. The facility failed to implement written policies and procedures that prohibit mistreatment and neglect which placed Resident #82 in immediate jeopardy (IJ) when staff failed to report mistreatment and neglect allegations to management, failed to protect the resident, failed to investigate and failed to report allegation of abuse/neglect to the state agency. The Administrator, Vice President and Director of Nursing (DON) were informed of this IJ identified on 9/13/12 at 10:30 AM. The facility provided surveyors with a written response on 9/14/12 at 5:30 PM for their abuse investigation process. This written response was determined to unacceptable on 9/14/12. The IJ was considered present and ongoing at the time of exit. The findings included: Review of the facility's "ABUSE" policy documented..." It shall be the policy of Americare Health and Rehabilitation Center to ensure that all of its residents receive professional, humane, and compassionate medical and nursing care... 1. Verbal Abuse: Any use of oral, written or gestured language that includes derogatory terms to the resident, their families or is stated within hearing	F 224			

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F 224	Continued From page 43 distances to describe a resident(s)... 3. Physical Abuse: Behavior that includes, hitting slapping... mental anguish or the deprivation of needed services... REPORTING THE INCIDENT: 1. Initially notify the Social Services personnel to intervene, and interview the resident(s) involved. 2. Notify the Director of Nursing [DON] and the Administrator of all reported alleged incidents of abuse... Management personnel shall assess, investigate and report all signs of suspect abuse... In the event that a possible incident of abuse has been reported, management personnel will conduct an investigation as follows: 1. Identify all parties involved... 2. Identify any witnesses's... 3. Conduct an immediate interview(s) of the persons involved in the alleged abuse and document... 4. Immediately provide a safe environment for the resident involved in the alleged incident... 5. If an employee is involved in the suspected abuse, the employee will be suspended with pay, pending completed investigation of the alleged incident... 6. If another resident is involved, after the investigation has been completed, the resident will be returned to their assigned room or nursing unit and a room change will be made, if needed..." Medical record review for Resident #82 documented an admission date of 1/5/11 with diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus Type I, Hypertension, Chronic Renal Disease, Bipolar Disorder, Hypothyroidism, Gout, Obesity, and Defiant Behavior. Review of the annual minimum data set (MDS) dated 6/14/12 documented in section C for cognitive patterns that Resident #82 was scored as "15" indicating the resident is cognitively intact.	F 224			

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F 224	Continued From page 44 Resident #82 reported the following three allegations of abuse to the surveyor: a. During an interview in Resident #28's room on 9/12/12 at 8:20 AM, Resident #82 was asked if she was treated with respect and dignity by the staff. Resident #82 stated, "Some days [named certified nursing assistant (CNA) #2] is in one of her moods. She [CNA #2] talks to me like a little child, like she is my parent. One day she came in here and said if I blow that horn again I'm going to send you out. She [CNA #2] tried to say I had a horn and was blowing it and acting out... She said I was going to go back to [named hospital]... She [CNA #2] threatens me with that all the time and makes me afraid. I told the supervisor." During an interview at the 1st McRee nurses station on 9/13/12 at 9:15 AM, Nurse #4 was asked if she received a report of an allegation of abuse involving CNA #2 talking to Resident #82 in a demeaning way and threatening to have her sent out." Nurse #4 stated, "I remember her [Resident #82] telling me that... said it was something about a horn that was blowing... said the aide told her she would be sent back to [named hospital]. Nurse #4 was asked if the incident was investigated. Nurse #4 stated, "I didn't investigate. I reported it to the Social Worker (SW). I never heard anything else about it." During an interview in the SW's office on 9/13/12 at 3:40 PM, the SW was asked if Resident #82's allegation of abuse was investigated. The SW stated, "I talked to [named Resident #82] about the incident... I didn't officially investigate. I guess that would [responsible for investigating] be	F 224			

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F 224	<p>Continued From page 45</p> <p>[named Administrator]... She [Resident #82] told me she was upset..."</p> <p>b. During an interview Resident #28's room on 9/13/12 at 4:35 PM, Resident #82 stated, "[Named CNA #16] called me names... called me "devil" and said "you are no good." I reported to the head nurse [Director of Nursing (DON)]. [Named CNA #16] was taken off my assignment."</p> <p>During an interview in the DON's office on 9/14/12 at 10:12 AM, the DON was asked if an allegation of abuse involving Resident #82 had been investigated. The DON stated, "I kind of remember her talking about [named CNA #16]... She may have said something about how he talked to her, but it would be because he is a male. He was moved from her assignment... She did not tell me anything that seemed abusive."</p> <p>During an interview in the Administrator's (Adm) office on 9/14/12 at 12:25 PM, the Adm stated, "I do remember being told she [Resident #82] had a problem with [named CNA #16] and Resident #82 had expressed this to the DON. I don't know where it went from that. If she felt this was an allegation of abuse I would expect her tell me right away." The Adm was asked if the DON reported the allegation. The Adm stated, "No. She [DON] told me she was looking into something that happened, but she did not tell me of an abusive situation."</p> <p>During an interview in the Adm's office on 9/17/12 at 9:30 AM, the Adm was asked if he considered being called "devil" and telling a resident "you are no good" abusive. The Adm stated, "By all means, I would consider that verbal abuse." The</p>	F 224			

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F 224	<p>Continued From page 46</p> <p>Adm was asked if the allegation had been investigated and reported. The Adm stated, "I'll have to ask..."</p> <p>c. During an interview in Resident #82's room on 9/13/12 at 4:20 PM, Resident #82 was asked if she was changed timely when wet with urine. Resident #82 stated, "Sometimes they do. Depends on who is working... They tell me I have sores on my bottom. It hurts sometimes."</p> <p>During an interview in Resident #82's room on 9/14/12 at 8:51 AM, Resident #82 stated, "My call light is broke. I had to use my cell phone to call my nurse last night. I called [named Nurse #11] on my cell phone and I called the head nurse [Nurse #16] later. [Named Nurse #16] said there was nothing she could do about them [staff] not changing me because it was on 3 to 11 shift and they [staff] were gone. She [Nurse #16] didn't get anybody to change me. I was out of minutes [on the cell phone] so I couldn't call again. I laid here awhile and then I went to sleep. No one came back until 6 [6:00 am] this morning. I was changed then. I was wet for a long time. I told you they didn't always change me..."</p> <p>Observations in Resident #82's room on 9/14/12 at 10:24 AM, revealed Resident #82 had an open area on the left inner thigh, one open area on the right inner thigh, and one open area on the right buttock. There was no dressing on any of the wounds.</p> <p>Resident #82 was left wet with urine during the 3/11 shift on 9/13/12 until 6:00 AM, resulting in the resident development of two new avoidable in house acquired stage II pressure ulcers; one on</p>	F 224			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 224	<p>Continued From page 47</p> <p>the left inner thigh and one on the right buttocks.</p> <p>During an interview in the DON's office on 9/14/12 at 10:12 AM, the DON was asked what was the process for handling an allegation of abuse. The DON stated, "...It's usually their [employees] word against the resident and I cannot prove anything. If they told me directly the employee was verbally abusive or physically rough I would report that. It just depends on what the resident tells me... If they say they cursed me, said ugly names, handled rough I know that is abuse. I report it immediately to Adm so he can start his investigation. The Adm reports it to the state because he is the abuse coordinator."</p> <p>During an interview at the nurses' station on 1st McRee on 9/14/12 at 4:25 PM, Nurse #2 stated, "I looked at her yesterday and tended to the area on the right inner thigh. There was nothing else. No other areas. If there is an area found it would be put on the log sheet and in the physician's communication book." There was no documentation of any report in the physician's communication book or the treatment log sheet.</p> <p>During an interview in the Administrator's office on 9/17/12 at 3:20 PM, the Adm was asked if he considered not changing a resident that was wet with urine a form of abuse. The Adm stated, "Yes, I would consider that a form of neglect."</p> <p>During an interview in the Administrator's office on 9/18/12 at 4:01 PM, the Adm was asked where he was in the investigation process related to the reported allegation of abuse by Resident #82 on 9/14/12. The Adm stated, "Not very far. I'll get on that in the morning unless you want it</p>	F 224			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 224	Continued From page 48 today."	F 224			
F 225 SS=K	<p>The facility failed to protect Resident #82 from mistreatment, neglect or abuse after being informed of the allegations and failure to implement the facility's abuse policy to prevent abuse placed Resident #82 in immediate jeopardy.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p>	F 225			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 225	<p>Continued From page 49</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, review of suspected abuse investigation form, review of the nursing schedules, review of time clock forms, medical record review, observation, and interview, it was determined the facility failed to ensure 6 of 38 (Residents #47, 81, 14, 68, 82, and 116) sampled residents reviewed included in the stage 2 review were free from physical, verbal or resident to resident abuse. The facility failed to ensure that allegations of abuse were reported immediately to the Administrator; allegations of abuse and injuries of unknown origin were thoroughly investigated; protect residents during the investigation and report an injury of an unknown origin and allegations of abuse to the state survey agency which placed Residents #47, 81, 14, 68, 82, and 116 in immediate jeopardy (IJ). The Administrator, Vice President and Director of Nursing (DON) were informed of this IJ identified on 9/13/12 at 10:30 AM. The facility provided surveyors with a written response on 9/14/12 at 5:30 PM for their abuse investigation process. This written response was determined to be unacceptable on 9/14/12. The IJ was considered present and ongoing at the time of exit.</p>	F 225			

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F 225	Continued From page 50 The findings included: 1. Review of the facility's "ABUSE" policy documented, "It shall be the policy of Americare Health and Rehabilitation Center to ensure that all of its residents receive professional, humane, and compassionate medical and nursing care that is free from verbal... 1. Verbal Abuse: Any use of oral, written or gestured language that includes derogatory terms to the resident, their families or is stated within hearing distances to describe a resident(s)... 3. Physical Abuse: Behavior that includes, hitting slapping... 6. Resident to Resident: Behavior between one resident to another that results in injury, pain, mental anguish or the deprivation of needed services... REPORTING THE INCIDENT: 1. Initially notify the Social Services personnel to intervene, and interview the resident(s) involved. 2. Notify the Director of Nursing [DON] and the Administrator of all reported alleged incidents of abuse... Management personnel shall assess, investigate and report all signs of suspect abuse.. In the event that a possible incident of abuse has been reported, management personnel will conduct an investigation as follows: 1. Identify all parties involved... 2. Identify any witnesses's... 3. Conduct an immediate interview(s) of the persons involved in the alleged abuse and document... 4. Immediately provide a safe environment for the resident involved in the alleged incident... 5. If an employee is involved in the suspected abuse, the employee will be suspended with pay, pending completed investigation of the alleged incident... 6. If another resident is involved, after the investigation has been completed, the resident will be returned to their assigned room or nursing unit and a room change will be made, if	F 225			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 225	<p>Continued From page 51 needed..."</p> <p>2. Medical record review for Resident #47 documented the resident admitted on 7/27/09 with diagnoses of Spina Bifida, Paraplegia, Anemia, Gastro Intestinal Hemorrhage, Major Depressive Disorder with Psychosis, Deep Vein Thrombosis and Hypertension. The annual Minimum Data Set (MDS) dated 5/31/12 and the quarterly MDS dated 3/8/12 documented the resident with a cognitive score of 15, indicating severe impairment.</p> <p>Nurses note dated 6/3/12 documented, "Resident came to this nurse while I was passing meds [medications], stated she was outside sitting in mobile chair next to her friend, stated, CNA [certified nursing assistant #14] started arguing with her, they both got into an argument, the quarrel escalated to 1st Magoffin hall, she said CNA #14 put her hand on resident forehead and the other [hand] on her throat, started choking her and slap her face. tiny scratch noted to lt. [left] side of face... will continue to monitor..." The record documented the nurse notified the responsible party of the incident.</p> <p>During an interview in Resident #47's room on 9/19/12 at 8:00 AM, Resident #47 stated, "Been here 3 years... Yes, a CNA she tried to choke me, her name is [named CNA #14], yes, she has continued to take care of me, I told the nurse."</p> <p>During an interview in the conference room on 9/18/12 at 5:00 PM, the Administrator stated, "No, was not aware of this [allegation of abuse] until today. I have talked with the CNA involved [CNA #14] and she has been suspended until the</p>	F 225			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 225	<p>Continued From page 52 investigation completed.</p> <p>The facility was unable to provide documentation that an incident report was completed, the staff failed to immediately report an alleged allegation of abuse to management, failed to ensure an allegation of abuse was thoroughly investigated, failed to report an allegation of abuse to the state survey agency and failed to protect the resident from further potential abuse which placed Resident #47 in IJ.</p> <p>3. Medical record review for Resident #81 documented the resident admitted on 6/15/07 and readmitted 7/16/12 with diagnoses of Cerebral Vascular Accident, Hypertension, Vascular Dementia, Above the Knee Amputation of left leg, and Peripheral Vascular Disease. The annual MDS dated 3/1/12 documented a cognitive score of 7 indicating severe impairment, no behaviors, no falls, no wounds and extensive to total care with activity of daily living. The quarterly MDS dated 8/16/12 documented a cognitive score of 5 indicating severe impairment, no behaviors, no falls and no wounds.</p> <p>During an interview in the conference room on 9/11/12 at 10:30 AM, the family of Resident #81 stated, "Nurse [named Nurse #10] on Saturday 9/8/12 ripped cover off of wound, wound bled and he wiped it, showing no compassion, [Nurse #10] got very loud and rude when asked to see his supervisor. [Nurse #10] said, "I'm black, that's why I'm loud." [Nurse #10] said he had 36 patients and was over this entire building, you are not the RP [responsible party] we cannot speak to ya'll..."</p>	F 225			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 225	<p>Continued From page 53</p> <p>During an interview in the conference room on 9/11/12 at 11:00 AM, the Administrator was informed of the wound of unknown origin noted on 8/25/12 and of the incident voiced by the family member that occurred on 9/8/12. The Administrator stated, "Will contact RP and get the process started..."</p> <p>During an interview in the conference room on 9/13/12 at 11:30 AM, Nurse #10 was asked if he had ever been accused or involved in a abuse investigation. Nurse #10 stated, "Yes, about a year ago was accused of an inappropriate statement to a resident, was suspended and after investigation, it was found okay and they brought me back, then about 4 to 6 months ago a resident accused me of pulling a plug of her hair out. They found she [Resident #81] had told a CNA she planned to get my job and had requested hair from the brush." Nurse #10 was asked about Resident #81's wound care. Nurse #10 stated, "The CNA [named #2] told me about the area [8/25/12], I assessed it, cleaned and dressed it. I notified the physician and put a note in book for wound nurse to evaluate it. I did not notify family of the wound. The wound was open and bleeding... I was the supervisor that day and the next day and reported it to [named Vice President] on Sunday [8/26/12]... as an injury of unknown origin..."</p> <p>During an interview in the conference room on 9/13/12 at 4:50 PM, the Vice President (VP) was asked if Resident #81's injury of the unknown origin had been reported to her. The VP stated, "No, do not recall any report of an injury."</p> <p>During an interview in 1st McRee nurses' station</p>	F 225			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 225	<p>Continued From page 54</p> <p>on 9/14/12 at 7:15 AM, CNA #2 was asked about Resident #81's wound. CNA #2 stated, "Yes, I found [named Resident #81's] wound. I was giving him his bath on Saturday 8/25/12, I called for [named Nurse #10], he came and took care of it. I worked on 8/24/12 and it [wound] was not there. I told [named Vice President] about it on Sunday 8/26/12 and she told me she was going to let the doctor know about it."</p> <p>Observations in Resident #81's room on 9/17/12 at 10:00 AM, Resident #81 looked at the surveyor, nodded his head but was non verbal, with a dressing noted on his left upper chest area. Nurse #1 removed the dressing that was dated 9/15/12 from the left upper chest area revealing a wound approximately 3 inches long, 1/2 inches wide with lower 1/2 of wound bed open red and raw and upper part of wound was pink.</p> <p>Review of the August 2012 and September 2012 nursing schedules which are completed by the Vice President and review of the time clock correction forms signed by the supervisor documented Nurse #10 did work the date of the incident on 8/25/12, and on 8/26/12 the date that the incident was reported to the Vice President. The schedule and time clock forms revealed Nurse #10 worked 8/27/12, 8/28/12, 8/31/12, 9/1/12, 9/2/12, 9/4/12, 9/5/12, 9/6/12, 9/7/12, 9/10/12, 9/11/12, and 9/13/12. Nurse #10 continued to work and care for the resident after this alleged incident had been reported to the Vice President on 8/26/12.</p> <p>The facility staff failed to protect Resident #81 from potential abuse after the VP was notified of the injury of unknown origin on 8/26/12. On</p>	F 225			

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F 225	<p>Continued From page 55</p> <p>9/11/12 the Administrator was informed of the 8/25/12 injury of unknown origin and the allegation of alleged abuse that occurred on 9/8/12.</p> <p>The facility failed to protect Resident #81 from potential abuse when Nurse #10 continued to work and care for Resident #81 after being accused of an alleged abuse incident on 9/8/12. Nurse #10 was not suspended from work until 9/14/12.</p> <p>The facility was unable to provide documentation that an incident report was completed for an injury of an unknown origin and an allegation of abuse; the staff failed to immediately report an injury of an unknown origin and an allegation of abuse to management; failed to ensure an injury of an unknown origin and an allegation of abuse were thoroughly investigated, failed to report an injury of an unknown origin and an allegation of abuse to the state survey agency and failed to protect the resident from further potential abuse which placed Resident #81 in IJ.</p> <p>4. Medical record review for Resident #14 documented an admission date 6/16/09 with diagnoses of Diabetes Mellitus, Hypertension, Status Post Cerebrovascular Accident (CVA), Obesity, Bipolar Disorder, Constipation and Schizoaffective Disorder - Bipolar Type. Review of the annual MDS dated 12/8/11 documented, Resident #14 cognitive status scored "15" indicating being very cognitively aware and totally dependent on staff for bathing and toileting and that resident was always incontinent. The quarterly MDS dated 8/15/12 documented, cognitive status scored "11" indicating being</p>	F 225			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 225	<p>Continued From page 56</p> <p>cognitively aware and totally dependent on staff for bathing and always incontinent.</p> <p>During an interview in Resident #14's room on 9/10/12 beginning at 5:30 PM, Resident #14 was asked do you ever feel afraid because of the way you or some other resident are treated. Resident #14 stated, "Yes." Resident #14 was asked have you ever been treated roughly by staff. Resident #14 stated, "Yes." Resident #14 was asked if it was reported to anyone. Resident #14 stated, "No, I did not report them because I don't know who is the head nurse..." Resident #14 was asked has staff yelled or been rude to you. Resident #14 stated, "Yes... I ask them to wash my feet and legs and they say turn over here... I will beat your butt... they pull my bed away from the wall [so can't reach call light] they tell me don't push that call light... no nurses have said this, only CNAs..."</p> <p>During an interview in Resident #14's room on 9/12/12 at 4:00 PM, Resident #14 was asked again if she had ever been treated roughly by staff. Resident #14 stated, "Yes... that girl said turn over here and act right, she held my feet to the bed and squeezed my toes together... this is the only rough treatment that I've had... they [CNAs] never wash your legs or feet... they only want to wash the upper part..." Resident #14 was asked do you want to report this to the Director of Nursing. Resident #14 stated, "Yes, I'll talk to her..."</p> <p>During an interview in the DON's office on 9/12/12 at 4:20 PM, the DON was notified of Resident #14's request to talk to her. The DON was asked if she was aware that Resident #14</p>	F 225			

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F 225	<p>Continued From page 57</p> <p>was having some problems with a CNA. The DON stated, "...I didn't know... I will talk to her..."</p> <p>During an interview in Resident #14's room on 9/13/12 at 8:18 AM, Resident #14 was asked if the DON talked with her yesterday. Resident #14 stated, "Yes, she did..." Resident #14 was asked if she was comfortable with the DON's response. Resident #14 stated, "Yes."</p> <p>During an interview in the DON's office on 9/14/12 at 12:15 PM, the DON was asked if she had talked to Resident #14, when the investigation was started and the progress on Resident #14's allegation. The DON stated, "Yes, I talked to her yesterday [9/13/12]... the investigation was started on 9/13/12 at 1:50 PM, the employees who work over there all the time were taken into her room... she was unable to identify the employee... the investigation continues..."</p> <p>During an interview in the conference room on 9/18/12 at 8:50 AM, Nurse #4 was asked where the facility had gotten with the investigation. Nurse #4 stated, "...I was in on that. She [Resident #14] didn't identify anybody, I even took a couple of people from 1st Magoffin and she didn't identify anyone... the DON is not here and I don't know how far she had gotten with it [investigation]..."</p> <p>During an interview in the Administrator's office on 9/18/12 at 6:00 PM, the Administrator was asked about the status of the investigation for Resident #14's allegation of abuse by a staff member. The Administrator stated, "...I don't really know, but I will check on it and get back</p>	F 225			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 225	<p>Continued From page 58 with you..."</p> <p>During an interview in the front office on 9/19/12 at 7:30 AM, the Administrator confirmed the facility knew of Resident #14's allegation of abuse prior to the beginning of the survey [9/10/12]. The Administrator stated, "...I knew about the allegation about [named Resident #14] from her son, he called me on 9/7 and I told [named DON] about it on 9/8... Yes, I knew about it..."</p> <p>The facility failed to ensure staff knew who to report abuse to. The facility was unable to provide documentation that an incident report was completed after receiving an allegation of abuse; failed to conduct an investigation of the allegation of abuse that occurred on 9/7/12; failed to report the allegation of abuse to the state survey agency and failed to protect Resident #14 from abuse which resulted in Resident #14 being fearful and in IJ.</p> <p>5. Medical record review for Resident #68 documented an admission date of 1/22/10 with diagnoses of Cerebrovascular Accident, Hemiplegia, Hypertension, Musculoskeletal Disorder of the Neck, Osteoarthritis, Renal Insufficiency, Gastroenteritis, Diabetes Mellitus, Hypocholesterolemia, Callosities, Degenerative Joint Disease, Frequent Urination, and Epilepsy.</p> <p>Review of the complaint made by Resident #68 taken by the DON and the Administrator dated 9/6/12 at approximately 2:00 PM documented, "[Resident #68] reported that on Monday, September 3, 2012, after breakfast and smoke break, he went to the office to check on his monthly check. [Nurse #10] was standing in the</p>	F 225			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 225	<p>Continued From page 59</p> <p>hallway pointing "Go back to 1st floor." Resident #68 stated he replied "I'm going to check on some business." [Nurse #10] replied, "No, you go back now." Resident #68 states that "[Nurse #10] grabbed the back of his chair, swung him around hastily and pushed him toward the elevator." Resident #68 stated that he felt light-headed. Since then he has been having severe pain in his neck but has not reported this [pain in his neck at time of incident] to anyone. He stated he has reported the incident to the Social Worker. After reporting the pain to his nurse, [Resident #68] was examined by the Medical Director on 9/7/12, regarding his complaint of pain. Noted "Getting better-cervical disc several years ago." No changes were made in his plan of care."</p> <p>Review of the nurses notes dated 9/5/12 at 2:55 PM documented, "...Resident [#68] c/o [complained of] neck pain... Placed name in physician's book..."</p> <p>Review of a physician's note dated 9/7/12 documented, "...neck pain sev [several] days... Has H/O [history of] cervical disc surgery year ago..."</p> <p>Review of the facility's review of suspected abuse investigation form documented, "...EMPLOYEE [circled on the form] /WITNESS STATEMENT... Resident's Name (alleged victim): [Resident #68]... Employee [circled on the form] ...Name: [Nurse #10]..." All other information on the form was blank. Review of the "INVESTIGATION OF ALLEDGED [alleged]... Abuse... Pending..."</p> <p>Review of the September 2012 nursing schedules which are completed by the Vice President</p>	F 225			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 225	<p>Continued From page 60</p> <p>revealed Nurse #10 worked and continued to care for Resident #68 on 9/4/12, 9/5/12, 9/6/12, 9/7/12, 9/10/12, 9/11/12, and 9/13/12. Nurse #10 was not suspended from work until 9/14/12.</p> <p>Observations at the 1st Magoffin nurses station on 9/11/12 at 7:45 AM, revealed Nurse #10 standing at the medication cart.</p> <p>During an interview in Resident #68's room on 9/11/12 beginning at 9:30 AM, Resident #68 was asked a series of screening questions to determine if he was of a cognitive level so that he could be interviewed regarding the care and treatment he received at the facility. Resident #68 was determined to be interviewable. Resident #68 was asked, "Have you ever been treated roughly by staff?" Resident #68 replied, "... [Named nurse #10] handles residents roughly... about a month ago I went upstairs to check on my funds... it was the first of the month... and [Nurse #10] immediately told me to go back to my room and [Nurse #10] began shoving me around... turned me around in my wheelchair and my neck hurt... told the Director of Nursing... she said she would talk to him [Nurse #10]..."</p> <p>During an interview in the Administrator's office on 9/12/12 at 5:26 PM, the Administrator was asked what usually happens when an allegation of abuse occurs. The Administrator stated, "...I try to get the investigation done in 5 days but I am not always faithful in this... if it is a caregiver they are reassigned even if it is to another area... then I get all the statement... and make a decision..." The Administrator was asked if staff members are suspended according to the facility policy. The Administrator stated, "Yes." The</p>	F 225			

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F 225	<p>Continued From page 61</p> <p>Administrator was asked why Nurse #10 was not suspended after the allegation made by Resident #68. The administrator stated, "I don't think this is abuse..."</p> <p>During an interview in the conference room on 9/14/12 at 8:50 AM, the Administrator stated, "...We suspended [Nurse #10] this morning [9/14/12]. We told the Vice president he is not to be scheduled to work until the investigation is complete. We are investigating and getting statements at present..."</p> <p>During an interview in the Administrator's office on 9/18/12 at 11:00 AM, the Administrator confirmed that the investigation was still on-going.</p> <p>The facility failed to recognize abuse; protect residents from verbal, mental and physical harm; and failed to follow the facility's abuse policy for reporting and investigating abuse which placed Resident #68 in IJ.</p> <p>6. Medical record review for Resident #82 documented an admission date of 1/5/11 with diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus Type I, Hypertension, Chronic Renal Disease, Bipolar Disorder, Hypothyroidism, Gout, Obesity, and Defiant Behavior. Review of the annual MDS dated 6/14/12 documented in section C for cognitive patterns that Resident #82 was scored as "15" indicating the resident is cognitively intact.</p> <p>Resident #82 reported the following allegations of abuse to the surveyor:</p> <p>a. During an interview in Resident #82's on</p>	F 225			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 225	<p>Continued From page 62</p> <p>9/12/12 at 8:20 AM, Resident #82 was asked if she was treated with respect and dignity by the staff. Resident #82 stated, "Some days [named CNA #2] is in one of her moods. She [CNA #2] talks to me like a little child, like she is my parent. One day she came in here and said if I blow that horn again I'm going to send you out. She [CNA #2] tried to say I had a horn and was blowing it and acting out... She said I was going to go back to [named hospital]... She [CNA #2] threatens me with that all the time and makes me afraid. I told the supervisor."</p> <p>During an interview at the 1st McRee nurses' station on 9/13/12 at 9:15 AM, Nurse #4 was asked if she received a report of an allegation of abuse involving CNA #2 talking to Resident #82 in a demeaning way and threatening to have her sent out." Nurse #4 stated, "I remember her [Resident #82] telling me that... said it was something about a horn that was blowing... said the aide told her she would be sent back to [named hospital]. Nurse #4 was asked if the incident was investigated. Nurse #4 stated, "I didn't investigate. I reported it to the Social Worker (SW). I never heard anything else about it."</p> <p>During an interview in the SW's office on 9/13/12 at 3:40 PM, the SW was asked if Resident #82's allegation of abuse was investigated. The SW stated, "I talked to [named Resident #82] about the incident... I didn't officially investigate. I guess that would [responsible for investigating] be [named Administrator]... She [Resident #82] told me she was upset..."</p> <p>b. During an interview in Resident #82's room on</p>	F 225			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 225	<p>Continued From page 63</p> <p>9/13/12 at 4:35 PM, Resident #82 stated, "[Named CNA #16] called me names... called me "devil" and said "you are no good." I reported to the head nurse [DON]. [Named CNA #16] was taken off my assignment."</p> <p>During an interview in the DON's office on 9/14/12 at 10:12 AM, the DON was asked if an allegation of abuse involving Resident #82 had been investigated. The DON stated, "I kind of remember her talking about [named CNA #16]... She may have said something about how he talked to her, but it would be because he is a male. He was moved from her assignment... She did not tell me anything that seemed abusive."</p> <p>During an interview in the Administrator's (Adm) office on 9/17/12 at 9:30 AM, the Adm was asked if he considered being called "devil" and telling a resident "you are no good" abusive. The Adm stated, "By all means, I would consider that verbal abuse." The Adm was asked if the allegation had been investigated and reported. The Adm stated, "I'll have to ask..."</p> <p>During an interview in the Adm's office on 9/14/12 at 12:25 PM, the Adm stated, "I do remember being told she [Resident #82] had a problem with [named CNA #16] and Resident #82 had expressed this to the DON. I don't know where it went from that. If she felt this was an allegation of abuse I would expect her tell me right away." The Adm was asked if the DON reported the allegation. The Adm stated, "No. She [DON] told me she was looking into something that happened, but she did not tell me of an abusive situation."</p>	F 225			

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

PRINTED: 10/08/2012
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F 225	<p>Continued From page 64</p> <p>During an interview in the DON's office on 9/14/12 at 10:12 AM, the DON was asked what was the process for handling an allegation of abuse. The DON stated, "...It's usually their [employees] word against the resident and I cannot prove anything. If they told me directly the employee was verbally abusive or physically rough I would report that. It just depends on what the resident tells me... If they say they cursed me, said ugly names, handled rough I know that is abuse. I report it immediately to Adm so he can start his investigation. The Adm reports it to the state because he is the abuse coordinator."</p> <p>During an interview in the Administrator's office on 9/17/12 at 3:20 PM, the Adm was asked if he considered not changing a resident that was wet with urine a form of abuse. The Adm stated, "Yes, I would consider that a form of neglect."</p> <p>During an interview in the Administrator's office on 9/18/12 at 4:01 PM, the Adm was asked where he was in the investigation process related to the reported allegation of abuse by Resident #82 on 9/14/12. The Adm stated, "Not very far. I'll get on that in the morning unless you want it today."</p> <p>The facility failed to provide documentation of an incident report or an investigation of the allegation of abuse reported by Resident #82.</p> <p>The facility failed to protect Resident #82 from abuse after being informed of the allegations; failed to investigate an allegation of abuse and failed to report an allegation of abuse to the state survey agency which placed Resident #82 in IJ.</p>	F 225			

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F 225	<p>Continued From page 65</p> <p>7. Medical record review for Resident #116 documented an admission date of 9/8/11 with diagnoses of Alzheimer's Dementia, Aggressive Behaviors, Coronary Artery Disease, Diabetes Mellitus, Hypertension and Congestive Heart Failure. Review of the MDS with an assessment reference date (ARD) of 3/1/12 section E-Behaviors, E0200-Behavioral Symptoms-Presence and Frequency was coded as 1 indicating presence of physical behavioral symptoms directed toward others occurring 1 to 3 days. Section E0800-Rejection of Care-Presence and Frequency was coded as 2 indicating this behavior had occurred 4 to (-) 6 days, but less than daily. Review of the MDS with an ARD of 8/17/12 section E-Behaviors, E0800 Rejection of Care-Presence and Frequency was coded as 1 indicating this behavior occurred 1-3 days.</p> <p>Review of nurses notes documented the following:</p> <p>a. 2/4/12 - "...Resident very agitated and restless @ [at] dinner time towards staff and other residents. Resident refused to eat dinner, attempted to hit nurse and another resident... Aggressive @ times..."</p> <p>b. 3/20/12 - "...Aggressive towards other resident and staff..."</p> <p>c. 4/9/12 - "...confusion noted @ times with agitation..."</p> <p>d. 4/20/12 - "...Agitated @ times..."</p> <p>e. 9/5/12 - "...Resident hit another resident in the hallway on the 1st floor. No injuries noted to either resident. Resident stated, "hell yeah I hit the motherfucker" Im [I'm] sick of that motherfucker stealing shit from everybody." I tried to knock his motherfucking ass out of the w.c. [wheelchair]." Explained to resident he can not hit</p>	F 225			

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

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FORM APPROVED
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F 225	Continued From page 66 other residents. Resident [#116] stated "I'm gonna beat his ass if he steals from me again... Social worker notified and here to speak with residents. MD [Medical Doctor] notified and no new orders noted..." Review of Resident #116's care plan dated 3/1/12 and 8/23/12 had no documented aggressive behaviors, social service referrals or mental health referrals. Review of the social service notes from January 2012 to September 2012 there were no documented aggressive behaviors or mental health referrals. The nursing behavior assessment dated 9/21/11 had no documented behavior issues. There were no other behavior assessments documented since 9/21/11. The facility failed to monitor and address Resident #116's aggressive behaviors; failed to investigate the incident and report the incident of resident to resident abuse to the state agency which placed Resident #116 and other residents in IJ.	F 225			
F 226 SS=K	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced	F 226			

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

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OMB NO. 0938-0391

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F 226	Continued From page 67 by: Based on policy review, review of suspected abuse investigation form, review of nursing schedules, review of time clock form, medical record review, observation, and interview, it was determined the facility failed to implement abuse policies and procedures to prohibit physical, verbal, and resident to resident abuse for 6 of 38 (Residents #47, 81,14, 68, 82, and 116) sampled residents included in the stage 2 review. The facility failed to ensure that allegations of abuse were reported immediately to the Administrator; failed to report allegations of abuse and an injury of an unknown origin to the state survey agency; failed to investigate allegations of abuse and injury of unknown origin and failed to protect residents during investigations which placed Residents #14, 47, 68, 81, 82, and 116 in immediate jeopardy (IJ). The Administrator, Vice President and Director of Nursing (DON) were informed of this IJ identified on 9/13/12 at 10:30 AM. The facility provided surveyors with a written response on 9/14/12 at 5:30 PM for their abuse investigation process. This written response was determined to be unacceptable on 9/14/12. The IJ was considered present and ongoing at the time of exit. The findings included: 1. Review of the facility's "ABUSE" policy documented, "...It shall be the policy of Americare Health and Rehabilitation Center to ensure that all of its residents receive professional, humane, and compassionate medical and nursing care that is free from verbal, sexual and/or involuntary seclusion... 1. Verbal Abuse: Any use of oral, written or gestured language that includes	F 226			

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F 226	Continued From page 68 derogatory terms to the resident, their families or is stated within hearing distances to describe a resident(s)... 3. Physical Abuse: Behavior that includes, hitting slapping... 6. Resident to Resident: Behavior between one resident to another that results in injury, pain, mental anguish or the deprivation of needed services... REPORTING THE INCIDENT: 1. Initially notify the Social Services personnel to intervene, and interview the resident(s) involved. 2. Notify the Director of Nursing [DON] and the Administrator [Adm] of all reported alleged incidents of abuse... Management personnel shall assess, investigate and report all signs of suspect abuse... In the event that a possible incident of abuse has been reported, management personnel will conduct an investigation as follows: 1. Identify all parties involved... 2. Identify any witnesses's... 3. Conduct an immediate interview(s) of the persons involved in the alleged abuse and document... 4. Immediately provide a safe environment for the resident involved in the alleged incident... 5. If an employee is involved in the suspected abuse, the employee will be suspended with pay, pending completed investigation of the alleged incident... 6. If another resident is involved, after the investigation has been completed, the resident will be returned to their assigned room or nursing unit and a room change will be made, if needed..." 2. Medical record review for Resident #47 documented the resident admitted on 7/27/09 with diagnoses of Spina Bifida, Paraplegia, Anemia, Gastro Intestinal Hemorrhage, Major Depressive Disorder with Psychosis, Deep Vein Thrombosis and Hypertension. The annual Minimum Data Set (MDS) dated 5/31/12 and the	F 226			

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

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F 226	<p>Continued From page 69</p> <p>quarterly MDS dated 3/8/12 documented the resident with a cognitive intact and had exhibited no behaviors.</p> <p>Nurses note dated 6/3/12 documented, "Resident came to this nurse while I was passing meds [medications], stated she was outside sitting in mobile chair next to her friend, stated, CNA [certified nursing assistant #14] started arguing with her, they both got into an argument, the quarrel escalated to 1st Magoffin hall, she said CNA [#14] put her hand on resident forehead and the other [hand] on her throat, started choking her and slap her face. tiny scratch noted to lt. [left] side of face... will continue to monitor..." The record documented the nurse notified the responsible party of the incident.</p> <p>During an interview in Resident #47's room on 9/19/12 at 8:00 AM, Resident #47 stated, "Been here 3 years... Yes, a CNA she tried to choke me, her name is [named CNA #14], yes, she has continued to take care of me, I told the nurse."</p> <p>During an interview in the conference room on 9/18/12 at 5:00 PM, the Adm stated, "No, was not aware of this [allegation of abuse] until today, I have talked with the CNA involved [CNA #14] and she has been suspended until the investigation completed.</p> <p>The facility was unable to provide documentation of an incident report or investigation of this alleged abuse. There was no documentation that the nurse reported the allegation to management. There was no documentation that the nurse protected the resident from further potential abuse by the staff member.</p>	F 226			

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F 226	<p>Continued From page 70</p> <p>The facility failed to ensure the allegation of abuse was reported, the resident was protected, and the allegation was investigated according to facility policy which placed Resident #47 in IJ.</p> <p>3. Medical record review for Resident #81 documented the resident admitted on 6/15/07 and readmitted 7/16/12 with diagnoses of Cerebral Vascular Accident, Hypertension, Vascular Dementia, Above the Knee Amputation of left leg, and Peripheral Vascular Disease. The annual MDS dated 3/1/12 documented the resident cognitive status is severely impaired, had exhibited no behaviors, no falls, no wounds, extensive to total care with activity of daily living, no swallowing issues and on no anticoagulants. The quarterly MDS dated 8/16/12 documented a cognitive status of 5 which is severe impairment, exhibited no behaviors, no falls, no wounds, no swallowing issues, and on daily anticoagulants.</p> <p>During an interview in the conference room on 9/11/12 at 10:30 AM, the family of Resident #81 stated, "Nurse [named Nurse #10] on Saturday 9/8/12 ripped cover off of wound, wound bled and he wiped it, showing no compassion, [Nurse #10] got very loud and rude when asked to see his supervisor. [Nurse #10] said, "I'm black, that's why I'm loud." said he had 36 patients and was over this entire building, you are not the RP [responsible party] we cannot speak to ya'll..."</p> <p>During an interview in the conference room on 9/11/12 at 11:00 AM, the Adm was informed of the wound of unknown origin noted on 8/25/12 and of the incident voiced by the family member that occurred on 9/8/12. The Administrator stated,</p>	F 226			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
(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 226	<p>Continued From page 71</p> <p>"Will contact RP and get the process started..."</p> <p>During an interview in the conference room on 9/13/12 at 11:30 AM, Nurse #10 was asked if he had ever been accused or involved in a abuse investigation. Nurse #10 stated, "Yes, about a year ago was accused of an inappropriate statement to a resident, was suspended and after investigation, it was found okay and they brought me back, then about 4 to 6 months ago a resident accused me of pulling a plug of her hair out. They found she had told a CNA she planned to get my job and had requested hair from the brush." Nurse #10 was asked about Resident #81's wound care. Nurse #10 stated, "The CNA [named CNA #2] told me about the area [8/25/12], I assessed it, cleaned and dressed it. I notified the physician and put a note in book for wound nurse to evaluate it. I did not notify family of the wound. The wound was open and bleeding... I was the supervisor that day and the next day and reported it to [named Vice President] on Sunday [8/26/12]... as an injury of unknown origin..."</p> <p>During an interview in the conference room on 9/13/12 at 4:50 PM, the Vice President (VP) was asked if Resident #81's injury of the unknown origin had been reported to her. The VP stated, "No, do not recall any report of an injury."</p> <p>During an interview in 1st McRee nurses' station on 9/14/12 at 7:15 AM, CNA #2 was asked about Resident #81's wound. CNA #2 stated, "Yes, I found [named Resident #81] wound, I was giving him his bath on Saturday 8/25/12, I called for [named Nurse #10], he came and took care of it. I worked on 8/24/12 and it was not there, I told [named Vice President] about it on Sunday</p>	F 226			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 226	<p>Continued From page 72</p> <p>8/26/12 and she told me she was going to let the doctor know about it."</p> <p>Observations in Resident #81's room on 9/17/12 at 10:00 AM, Resident #81 looked at the surveyor, nodded his head but was non verbal, with a dressing noted on his left upper chest area. Nurse #1 removed the dressing that was dated 9/15/12 from the left upper chest area revealing a wound approximately 3 inches long, 1/2 inches wide with lower 1/2 of wound bed open red and raw and upper part of wound was pink.</p> <p>Review of the August 2012 and September 2012 nursing schedules which are completed by the VP and review of the time clock correction forms signed by the supervisor documented Nurse #10 had worked the date of the incident on 8/25/12, and on 8/26/12 the date that the incident was reported to the VP. The schedule and time clock forms revealed Nurse #10 worked 8/27/12, 8/28/12, 8/31/12, 9/1/12, 9/2/12, 9/4/12, 9/5/12, 9/6/12, 9/7/12, 9/10/12, 9/11/12, and 9/13/12. Nurse #10 continued to work and care for the resident after this alleged incident had been reported to the VP on 8/26/12.</p> <p>The facility was unable provide documentation of an incident report or an investigation into the reported injury of unknown origin.</p> <p>The facility staff failed to protect Resident #81 from potential abuse after the VP was notified of the injury of unknown on 8/26/12. On 9/11/12 the Adm was informed of the 8/25/12 injury of unknown origin and the allegation of alleged abuse that occurred on 9/8/12. The facility failed to protect Resident #81 from potential abuse</p>	F 226			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 226	<p>Continued From page 73</p> <p>when Nurse #10 continued to work and care for Resident #81 after being accused of an alleged abuse incident on 9/8/12. Nurse #10 was not suspended from work until 9/14/12. The facility failed to report the allegations on abuse to the state survey agency. The facility failed protect Resident #81 and failed to investigate the allegations of abuse which placed Resident #81 in JJ.</p> <p>4. Medical record review for Resident #14 documented an admission date 6/16/09 with diagnoses of Diabetes Mellitus, Hypertension, Status Post Cerebrovascular Accident (CVA), Obesity, Bipolar Disorder, Constipation and Schizoaffective Disorder - Bipolar Type. Review of the annual MDS dated 12/8/11 documented, Resident #14 cognitive status scored "15" indicating being very cognitively aware, totally dependent on staff for bathing and toileting and always incontinent. The quarterly MDS dated 8/15/12 documented, cognitive status scored "11" indicating being cognitively aware, totally dependent on staff for bathing and always incontinent.</p> <p>During an interview in Resident #14's room on 9/10/12 beginning at 5:30 PM, Resident #14 was asked do you ever feel afraid because of the way you or some other residents are treated. Resident #14 stated, "Yes." Resident #14 was asked have you ever been treated roughly by staff. Resident #14 stated, "Yes." Resident #14 was asked if it was reported to anyone. Resident #14 stated, "No, I did not report them because I don't know who is the head nurse..." Resident #14 was asked has staff yelled or been rude to you. Resident #14 stated, "Yes... I ask them to wash</p>	F 226			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 226	<p>Continued From page 74</p> <p>my feet and legs and they say turn over here... I will beat your butt... they pull my bed away from the wall [so can't reach call light] they tell me don't push that call light... no nurses have said this, only CNAs..."</p> <p>During an interview in Resident #14's room on 9/12/12 at 4:00 PM, Resident #14 was asked again if she had ever been treated roughly by staff. Resident #14 stated, "Yes... that girl said turn over here and act right, she held my feet to the bed and squeezed my toes together... this is the only rough treatment that I've had... they never wash your legs or feet... they only want to wash the upper part..." Resident #14 was asked do you want to report this to the Director of Nursing. Resident #14 stated, "Yes, I'll talk to her..."</p> <p>During an interview in the DON's office on 9/12/12 at 4:20 PM, the DON was notified of Resident #14's request to talk to her. The DON was asked if she was aware that Resident #14 was having some problems with a CNA. The DON stated, "...I didn't know... I will talk to her..."</p> <p>During an interview in Resident #14's room on 9/13/12 at 8:18 AM, Resident #14 was asked if the DON talked with her yesterday. Resident #14 stated, "Yes, she did..." Resident #14 was asked if she was comfortable with the DON's response. Resident #14 stated, "Yes."</p> <p>During an interview in the DON's office on 9/14/12 at 12:15 PM, the DON was asked if she had talked to Resident #14, when the investigation was started and the progress on Resident #14's allegation. The DON stated, "Yes,</p>	F 226			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 226	<p>Continued From page 75</p> <p>I talked to her yesterday [9/13/12]... the investigation was started on 9/13/12 at 1:50 PM, the employees who work over there all the time were taken into her room... she was unable to identify the employee... the investigation continues..."</p> <p>During an interview in the conference room on 9/18/12 at 8:50 AM, Nurse #4 was asked where the facility had gotten with the investigation. Nurse #4 stated, "...I was in on that, she [Resident #14] didn't identify anybody, I even took a couple of people from 1st Magoffin and she didn't identify anyone... the DON is not here and I don't know how far she had gotten with it [investigation]..."</p> <p>During an interview in the Adm's office on 9/18/12 at 6:00 PM, the Adm was asked about the status of the investigation for Resident #14's allegation of abuse by a staff member. The Adm stated, "...I don't really know, but I will check on it and get back with you..."</p> <p>During an interview in the front office on 9/19/12 at 7:30 AM, the Adm confirmed the facility knew of Resident #14's allegation of abuse prior to the beginning of the survey [9/10/12]. The Adm stated, "...I knew about the allegation about [named Resident #14] from her son, he called me on 9/7 and I told [named DON] about it on 9/8... Yes, I knew about it..."</p> <p>The facility was unable to provide documentation of an investigation or an incident report for Resident #14's allegation of abuse.</p> <p>The facility failed to ensure a resident knew who</p>	F 226			

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F 226	<p>Continued From page 76</p> <p>to report abuse to; protect Resident #14 from abuse after being informed of the allegations of abuse on 9/7/12; and failed to follow the facility policy for reporting and/or investigating allegations of abuse which placed Resident #14 in IJ.</p> <p>5. Medical record review for Resident #68 documented an admission date of 1/22/10 with diagnoses of Cerebrovascular Accident, Hemiplegia, Hypertension, Musculoskeletal Disorder of the Neck, Osteoarthritis, Renal Insufficiency, Gastroenteritis, Diabetes Mellitus, Hypocholesterolemia, Callosities, Degenerative Joint Disease, Frequent Urination, and Epilepsy.</p> <p>Review of the complaint made by Resident #68 taken by the DON and the Adm dated 9/6/12 at approximately 2:00 PM documented, "[Resident #68] reported that on Monday, September 3, 2012, after breakfast and smoke break, he went to the office to check on his monthly check. [Nurse #10] was standing in the hallway pointing "Go back to 1st floor." Resident #68 stated he replied "I'm going to check on some business." [Nurse #10] replied, "No, you go back now." Resident #68 states that "[Nurse #10] grabbed the back of his chair, swung him around hastily and pushed him toward the elevator." Resident #68 stated that he felt light-headed. Since then he has been having severe pain in his neck but has not reported this [the pain in his neck at time of incident] to anyone. He stated he has reported the incident to the Social Worker. After reporting the pain to his nurse, [Resident #68] was examined by the Medical Director on 9/7/12, regarding his complaint of pain. Noted "Getting better-cervical disc several years ago." No</p>	F 226			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 226	<p>Continued From page 77</p> <p>changes were made in his plan of care."</p> <p>Review of the nurses notes dated 9/5/12 at 2:55 PM documented, "...Resident [#68] c/o [complained of] neck pain... Placed name in physician's book..."</p> <p>Review of a physician's note dated 9/7/12 documented, "...neck pain sev [several] days... Has H/O [history of] cervical disc surgery year ago..."</p> <p>Review of the facility's review of suspected abuse investigation form documented, "...EMPLOYEE [circled on the form] /WITNESS STATEMENT... Resident's Name (alleged victim): [Resident #68]... Employee [circled on the form] ...Name: [Nurse #10]..." All other information on the form was blank. Review of the "INVESTIGATION OF ALLEDGED [alleged]... Abuse... Pending..."</p> <p>Review of the September 2012 nursing schedules which are completed by the Vice President revealed Nurse #10 worked and continued to care for Resident #68 on 9/4/12, 9/5/12, 9/6/12, 9/7/12, 9/10/12, 9/11/12, and 9/13/12. Nurse #10 was not suspended from work until 9/14/12.</p> <p>Observations at the 1st Magoffin nurses station on 9/11/12 at 7:45 AM, revealed Nurse #10 standing at the medication cart.</p> <p>During an interview in Resident #68's room on 9/11/12 beginning at 9:30 AM, Resident #68 was asked a series of screening questions to determine if he was of a cognitive level so that he could be interviewed regarding the care and treatment he received at the facility. Resident</p>	F 226			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 226	<p>Continued From page 78</p> <p>#68 was determined to be unreviewable. Resident #68 was asked, "Have you ever been treated roughly by staff?" Resident #68 replied, "...[Named nurse #10] handles residents roughly... about a month ago I went upstairs to check on my funds... it was the first of the month... and [Nurse #10] immediately told me to go back to my room and [Nurse #10] began shoving me around... turned me around in my wheelchair and my neck hurt... told the Director of Nursing... she said she would talk to him [Nurse #10]..."</p> <p>During an interview in the Adm's office on 9/12/12 at 5:26 PM, the Adm was asked what usually happens when an allegation of abuse occurs. The Adm stated, "...I try to get the investigation done in 5 days but I am not always faithful in this... if it is a caregiver they are reassigned even if it is to another area... then I get all the statement... and make a decision..." The Adm was asked if staff members are suspended according to the facility policy. The Adm stated, "Yes." The Adm was asked why Nurse #10 was not suspended after the allegation made by Resident #68. The Adm stated, "I don't think this is abuse..."</p> <p>During an interview in the conference room on 9/14/12 at 8:50 AM, the Adm stated, "...We suspended [Nurse #10] this morning. We told the Vice President he [Nurse #10] is not to be scheduled to work until the investigation is complete. We are investigating and getting statements at present..."</p> <p>During an interview in the Adm's office on 9/18/12 at 11:00 AM, the Adm confirmed that the investigation was still on-going.</p>	F 226			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 226	<p>Continued From page 79</p> <p>The facility staff failed to recognize abuse; protect residents from abuse; and failed to implement the abuse policy for reporting and/or investigating allegations of abuse which placed Resident #68 in IJ.</p> <p>6. Medical record review for Resident #82 documented an admission date of 1/5/11 with diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus Type I, Hypertension, Chronic Renal Disease, Bipolar Disorder, Hypothyroidism, Gout, Obesity, and Defiant Behavior. Review of the annual MDS dated 6/14/12 documented in section C for cognitive patterns that Resident #82 was scored as "15" indicating the resident is cognitively intact.</p> <p>Resident #82 reported the following allegations of abuse to the surveyor: a. During an interview in Resident #82's room on 9/12/12 at 8:20 AM, Resident #82 was asked if she was treated with respect and dignity by the staff. Resident #82 stated, "Some days [named CNA #2] is in one of her moods. She [CNA #2] talks to me like a little child, like she is my parent. One day she came in here and said if I blow that horn again I'm going to send you out. She [CNA #2] tried to say I had a horn and was blowing it and acting out... She said I was going to go back to [named hospital]... She [CNA #2] threatens me with that all the time and makes me afraid. I told the supervisor."</p> <p>During an interview at the 1st McRee nurses' station on 9/13/12 at 9:15 AM, Nurse #4 was asked if she received a report of an allegation of</p>	F 226			

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

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OMB NO. 0938-0391

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F 226	<p>Continued From page 80</p> <p>abuse involving CNA #2 talking to Resident #82 in a demeaning way and threatening to have her sent out." Nurse #4 stated, "I remember her [Resident #82] telling me that... said it was something about a horn that was blowing... said the aide told her she would be sent back to [named hospital]. Nurse #4 was asked if the incident was investigated. Nurse #4 stated, "I didn't investigate. I reported it to the Social Worker (SW). I never heard anything else about it."</p> <p>During an interview in the SW's office on 9/13/12 at 3:40 PM, the SW was asked if Resident #82's allegation of abuse was investigated. The SW stated, "I talked to [named Resident #82] about the incident... I didn't officially investigate. I guess that would [responsible for investigating] be [named Administrator]... She [Resident #82] told me she was upset..."</p> <p>b. During an interview in Resident #82's room on 9/13/12 at 4:35 PM, Resident #82 stated, "[Named CNA #16] called me names... called me "devil" and said "you are no good." I reported to the head nurse [DON]. [Named CNA #16] was taken off my assignment."</p> <p>During an interview in the DON's office on 9/14/12 at 10:12 AM, the DON was asked if an allegation of abuse involving Resident #82 had been investigated. The DON stated, "I kind of remember her talking about [named CNA #16]... She may have said something about how he talked to her, but it would be because he is a male. He was moved from her assignment... She did not tell me anything that seemed abusive."</p>	F 226			

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

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F 226	<p>Continued From page 81</p> <p>During an interview in the Adm's office on 9/17/12 at 9:30 AM, the Adm was asked if he considered being called "devil" and telling a resident "you are no good" abusive. The Adm stated, "By all means, I would consider that verbal abuse." The Adm was asked if the allegation had been investigated and reported. The Adm stated, "I'll have to ask..."</p> <p>During an interview in the Adm office on 9/14/12 at 12:25 PM, the Adm stated, "I do remember being told she [Resident #82] had a problem with [named CNA #16] and Resident #82 had expressed this to the DON. I don't know where it went from that. If she felt this was an allegation of abuse I would expect her tell me right away." The Adm was asked if the DON reported the allegation. The Adm stated, "No. She [DON] told me she was looking into something that happened, but she did not tell me of an abusive situation."</p> <p>During an interview in the DON's office on 9/14/12 at 10:12 AM, the DON was asked what was the process for handling an allegation of abuse. The DON stated, "...It's usually their [employees] word against the resident and I cannot prove anything. If they told me directly the employee was verbally abusive or physically rough I would report that. It just depends on what the resident tells me... If they say they cursed me, said ugly names, handled rough I know that is abuse. I report it immediately to Adm so he can start his investigation. The Adm reports it to the state because he is the abuse coordinator."</p> <p>During an interview in the Adm's office on 9/17/12 at 3:20 PM, the Adm was asked if he considered</p>	F 226			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 226	<p>Continued From page 82</p> <p>not changing a resident that was wet with urine a form of abuse. The Adm stated, "Yes, I would consider that a form of neglect."</p> <p>During an interview in the Adm's office on 9/18/12 at 4:01 PM, the Adm was asked where he was in the investigation process related to the reported allegation of abuse by Resident #82 on 9/14/12. The Adm stated, "Not very far. I'll get on that in the morning unless you want it today."</p> <p>The facility failed to provide documentation of an incident report or an investigation of the allegation of abuse reported by Resident #82.</p> <p>The facility failed to protect Resident #82 from abuse after being informed of the allegations; failed to investigate and report allegations of abuse to the state survey agency which placed Resident #82 in IJ.</p> <p>7. Medical record review for Resident #116 documented an admission date of 9/8/11 with diagnoses of Alzheimer's Dementia, Aggressive Behaviors, Coronary Artery Disease, Diabetes Mellitus, Hypertension, and Congestive Heart Failure. Review of the MDS with an assessment reference date (ARD) of 3/1/12 section E-Behaviors, E0200-Behavioral Symptoms-Presence and Frequency was coded as 1 indicating presence of physical behavioral symptoms directed toward others occurring 1 to 3 days. Section E0800-Rejection of Care-Presence and Frequency was coded as 2 indicating this behavior had occurred 4 to (-) 6 days, but less than daily. Review of the MDS with an ARD of 8/17/12 section E-Behaviors, E0800 Rejection of Care-Presence and Frequency was coded as 1</p>	F 226			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 226	<p>Continued From page 83 indicating this behavior occurred 1-3 days.</p> <p>Review of nurses notes documented the following:</p> <p>a. 2/4/12 - "...Resident very agitated and restless @ [at] dinner time towards staff and other residents. Resident refused to eat dinner, attempted to hit nurse and another resident... Aggressive @ times..."</p> <p>b. 3/20/12 - "...Aggressive towards other resident and staff..."</p> <p>c. 4/9/12 - "...confusion noted @ times with agitation..."</p> <p>d. 4/20/12 - "...Agitated @ times..."</p> <p>e. 9/5/12 - "...Resident hit another resident in the hallway on the 1st floor. No injuries noted to either resident. Resident stated, "hell yeah I hit the mother fucker" Im [I'm] sick of that mother fucker stealing shit from everybody." I tried to knock his motherfucking ass out of the w.c. [wheelchair]." Explained to resident he can not hit other residents. Resident [#116] stated "I'm gonna beat his ass if he steals from me again... Social worker notified and here to speak with residents. MD [Medical Doctor] notified and no new orders noted..."</p> <p>Review of Resident #116's care plan dated 3/1/12 and 8/23/12 had no documented aggressive behaviors, social service referrals or mental health referrals.</p> <p>Review of the social service notes from January 2012 to September 2012 there were no documented aggressive behaviors or mental health referrals.</p> <p>The nursing behavior assessment dated 9/21/11</p>	F 226			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 226	Continued From page 84 had no documented behavior issues. There were no other behavior assessments documented since 9/21/11.	F 226			
F 241 SS=G	The facility failed to implement the facility's policy to monitor and address Resident #116's aggressive behaviors which placed Resident #116 and other residents in IJ. 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, it was determined the facility failed to promote care for residents in a manner that maintained or enhanced residents' dignity and respect for 4 of 38 (Residents #82, 6, 30 and 84) sampled residents included in the stage 2 review. The facility failed to promote resident dignity by not knocking prior to entering resident rooms or standing while feeding during 1 of 2 (Supper Meal on 9/10/12) dining observations. The facility failed to maintain dignity and respect of a resident when staff knowingly left her wet with urine during the evening and night shift, which resulted in the development of two new avoidable in house acquired stage II pressure ulcers which caused actual harm to Resident #82. The findings included:	F 241			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 241	<p>Continued From page 85</p> <p>1. Medical record review for Resident #82 documented an admission date of 1/5/11 with diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus Type I, Hypertension, Chronic Renal Disease, Bipolar Disorder, Hypothyroidism, Gout, Obesity, and Defiant Behavior. Review of the annual minimum data set (MDS) dated 6/14/12 documented in section C for cognitive patterns that Resident #82 was scored as "15" indicating the resident is cognitively intact. Review of the facility's nurses notes for Resident #82 dated 9/4/12 documented, "...Staff encouraged to keep resident dry by changing briefs as much as possible... Resident requires... extensive /total ADL [Activities of Daily Living] care..." Review of the care plan dated 6/20/12 documented, "...POTENTIAL FOR PRESSURE ULCERS RELATED TO INCONTINENCE, IMPAIRED MOBILITY AND OBESITY... Turn and reposition resident q [every] 2 hours and prn [as needed]... PERINEAL CARE EVERY 2 HOURS..."</p> <p>During an interview in Resident #82's room on 9/13/12 at 4:20 PM, Resident #82 was asked if she was changed timely when wet with urine. Resident #82 stated, "Sometimes they do. Depends on who is working... They tell me I have sores on my bottom. It hurts sometimes."</p> <p>During an interview in Resident #82's room on 9/14/12 at 8:51 AM, Resident #82 stated, "My call light is broke. I had to use my cell phone to call my nurse last night [9/13/12]. I called [named Nurse #11] and I called the head nurse [Nurse #16] later. [Named Nurse #16] said there was nothing she could do about them not changing me because it was on 3 to 11 shift and they [staff]</p>	F 241			

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F 241	<p>Continued From page 86</p> <p>were gone. She [Nurse #16] didn't get anybody to change me. I laid here awhile and then I went to sleep. No one came back until 6 [6:00 AM] this morning. I was changed then. I was wet for a long time. I told you they didn't always change me."</p> <p>Observations in Resident #82's room on 9/14/12 at 10:24 AM, revealed Resident #82 had three stage II pressure ulcers; an open area on the left inner thigh, an open area on the right inner thigh, and an open area on the right buttock. There was no dressing on any of the wounds.</p> <p>An alert and oriented Resident #82, who is dependent on staff for ADL care, was left wet with urine in the bed during the 3/11 shift on 9/13/12 until 6:00 AM, resulting in the development of two new avoidable in house acquired stage II pressure ulcers; one on the left inner thigh and one on the right buttocks.</p> <p>During an interview at the nurses' station on 1st McRee on 9/14/12 at 4:25 PM, Nurse #2 stated, "I looked at her [Resident #82] yesterday [9/13/12] and tended to the area on the right inner thigh. There was nothing else. No other areas..."</p> <p>The facility failed to maintain dignity and respect of a resident when staff knowingly left her wet with urine during the evening and night shift, which resulted in the development of two new avoidable in house acquired stage II pressure ulcers which caused actual harm to Resident #82.</p> <p>2. Medical record review for Resident #6 documented an admission date of 5/15/00 with diagnoses of Paralysis Agitans, Hypertension, Osteoarthritis, Osteoporosis, Percutaneous</p>	F 241			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 241	<p>Continued From page 87</p> <p>Endoscopy Gastrostomy tube (PEG), Adult Failure to Thrive, History of Cerebral Vascular Accident, Depressive Disorder, Neurogenic Bladder, and Osteopenia.</p> <p>Observations in Resident #6's room (2nd Magoffin) on 9/10/12 at 11:15 AM, revealed Resident #6's gown was threadbare and the bed linens were thin. Resident #6's skin could be seen through the threadbare gown.</p> <p>Observations in Resident #6's room (2nd Magoffin) on 9/10/12 at 5:10 PM, revealed Resident #6 had a very thin sheet over her.</p> <p>During a phone interview in the conference room on 9/12/12 at 8:50 AM, the family member of Resident #6 stated, "She [Resident #6] was dirty, not cared for, had holes in her garments, was soiled, the sheets were threadbare. I could not find a nurse at first, she [nurse] eventually came around but did not know anything about the patient... How can she effectively care for patient's if she doesn't know their history?"</p> <p>3. Observations in room 410 on 9/11/12 at 8:10 AM, revealed Resident #30 eating breakfast with his clothes having a strong smell of urine.</p> <p>4. Medical record review for Resident #84 documented an admission date of 4/11/08 with diagnoses of Senile Dementia, Esophageal Reflux, Osteoporosis, Hypertension, and Closed Fracture of Lumbar Spine. Review of the care plan dated 7/18/12 documented, "...Bath daily; oral care daily and prn [as needed]; hair groomed daily; nails checked daily for cleanliness and trimmed once a week... provide clean, seasonal</p>	F 241			

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F 241	<p>Continued From page 88</p> <p>clothing daily and pm... pearineal [perineal] care every two hours..."</p> <p>Observations in Resident #84's room on 9/10/12 at 1:00 PM, revealed Resident #84 in bed wearing a thin hospital gown. Her nails were unkept, long and dirty, wig was unstyled and tipped forward down toward eyes.</p> <p>Observations in Resident #84's room on 9/11/12 at 8:00 AM, 12:00 PM and 2:00 PM, revealed Resident #84 wearing a thin, threadbare hospital gown. Her wig was unstyled and slipping forward down above eyes. Her bed linens were thin and discolored; pillowcase dingy gray in color.</p> <p>Observations in Resident #84's room on 9/12/12 at 9:00 AM, 12:00 PM and 3:00 PM, revealed Resident #84's nails were long and unkept; linens were thin and discolored.</p> <p>Observations and interview in Resident #84's room on 9/13/12 at 9:20 AM, revealed in Resident #84 was lying in bed with wet linens. Her nails remained long and dirty her toenails were unkept. Her wig was unstyled and slipping forward down above eyes. Resident #84 stated, "...I have not had a bath today..."</p> <p>During an interview in Resident #84's room on 9/13/12 at 9:30 AM, Resident #84 was asked if she was wet, Resident #84 answered, "Yes." Resident #84 was asked if she had had a bath this morning. Resident #84 stated, "...I haven't had anything done for me..." Resident #84 was asked if she ever removed her wig for hair care. Resident #84 stated, "...they never brush my hair... I wish they would..."</p>	F 241			

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

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OMB NO. 0938-0391

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F 241	Continued From page 89 During an interview on 1st McRee hall on 9/13/12 at 10:00 AM, Certified Nursing Assistant (CNA) #2 was asked about Resident #84's morning (9/13/12) care. CNA #2 stated, "...no I haven't bathed her yet... she was last changed on the 11-7 shift at 5:30 AM..." 5. Observations on 9/10/12 at 5:50 PM, revealed CNA #12 entered room 406 with a tray, without knocking prior to entering the room. Observations during the supper meal on 9/10/12 at 5:57 PM, CNA #12 entered room 404 without knocking prior to entering the room. 6. Observations in the 2nd Magoffin day room, during the supper meal on 9/10/12 at 5:55 PM, revealed Nurse #10 standing over a resident that was seated in a geri-chair while feeding the resident his supper.	F 241			
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, it was determined the facility failed to give a reasonable advance notification of room change for 2 of 2 (Residents #60 and 99) sampled residents with room changes of the 38 residents included in the stage 2 review.	F 247			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 247	<p>Continued From page 90</p> <p>The findings included:</p> <p>1. Medical record review of Resident #60's nurses notes dated 6/21/12 documented, "...new order for resident [Resident #60] to transfer to 1st McRee. No answer when trying to contact guarantor..." The facility was unable to provide documentation that Resident #60 had been given advance notification of a room change.</p> <p>During an interview in room 414 on 9/13/12 at 8:20 AM, Resident #60 was asked if he was given notice before being moved to room 414. Resident #60 stated, "They just brought me in here and told me then that I was being moved here."</p> <p>During an interview in the Social Service's (SS) office on 9/13/12 at 9:15 AM, the Social Worker (SW) stated, "We notify the resident and the family member." The SW was asked, "When was notice given to Resident #60 of the room change from 2nd Magoffin to 1st McRee?" The SW stated, "...I don't remember talking to him about a room change. Nursing may have done that. Should be documented in social service notes or sometimes on a face sheet. All I can tell you is in the nurses notes is where they should have documented [notice of room changes]."</p> <p>2. Medical record review of Resident #99's nurses' notes dated 6/8/12 documented, "...1pm... Res [resident] being transferred to 1st Mag [Magoffin] to rm [room] #119. R.P. [responsible party] contacted... to inform of Rm transfer... 2pm... Resident transferred to room 119... 4pm...(wife) made aware by day shift supervisor resident was not able to [be] moved back into old room due to call light system not</p>	F 247			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 247	Continued From page 91 functioning properly this nurse also made resident aware..." The facility was unable to provide documentation that Resident #99 was given advance notification of a room change. During an interview in room 119 on 9/10/12 4:55 PM, Resident #99 was asked if he was given notice before he was moved to room 119. Resident #99 stated, "No, just a couple of hours..." During an interview in the conference room on 9/13/12 at 4:57 PM, the SW was asked if notification of the room change was given to Resident #99 before he was moved. The SW stated, "No, I didn't notify him. I don't always know about every room change. Nursing should have told him about the change. That's all I know."	F 247			
F 250 SS=J	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on policy review, review of the Social Worker's (SW) job description, medical record review, observation and interview, it was determined the facility failed to ensure residents received the necessary care and services related to psychiatric services, dental or vision needs for 7 of 38 (Residents #116, 43, 60, 63, 68, 104, and 124) sampled residents included in the stage 2	F 250			

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

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F 250	<p>Continued From page 92</p> <p>review. Failure to provide the necessary psychiatric services related to behaviors resulted in an immediate jeopardy (IJ) for Resident #116. The Administrator, Facility Consultant, Vice President and the Nursing Supervisor were informed of this IJ on 9/20/12 at 6:00 PM. This IJ was considered present and ongoing at the time of exit.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility's "DENTAL / OPHTHALMOLOGY / OPTOMETRY SERVICES" policy documented, "...OBJECTIVE: In an effort to provide optimal quality of care to each resident. Diagnostic testing will be provided to maintain optimal function and timely treatment. PROCEDURE: 1. Obtain written order from MD [medical doctor] for needed services. 2. Send referral to assigned staff to set up appointment. (a) Dental referral to Social Services... 3. Notify Social Services for financial approval... If the resident has no payment source to cover treatment, Social Worker to call family and see if payment for services can be arranged. If no payment source found, the facility will pay for services..." 2. Review of the facility's "Social Worker" job description documented, "Provides... targeted intervention for social, emotional and environmental issues that impact client/family ability to optimally benefit from care. Actively collaborates with team to meet client care, outcome management and system improvement goals... 4. Maintains timely documentation. 4a. Consistently meets facility and regularly mandated documentation standards..." 	F 250			

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F 250	Continued From page 93 3. Medical record review for Resident #116 documented an admission date of 9/8/11 with diagnoses of Alzheimer's Dementia, Aggressive Behaviors, Coronary Artery Disease, Diabetes Mellitus, Hypertension and Congestive Heart Failure. Review of the Minimum Data Set (MDS) with an assessment reference date (ARD) of 3/1/12 section E-Behaviors, E0200-Behavioral Symptoms-Presence and Frequency was coded as 1 indicating presence of physical behavioral symptoms directed toward others occurring 1 to 3 days. Section E0800-Rejection of Care-Presence and Frequency was coded as 2 indicating this behavior had occurred 4 to (-) 6 days, but less than daily. Review of the MDS with an ARD of 8/17/12 section E-Behaviors, E0800 Rejection of Care-Presence and Frequency was coded as 1 indicating this behavior occurred 1-3 days. Review of nurses notes documented the following: a. 10/28/11 - "...refused dinner... refuses skin assessment by staff... stays in room with door shut and privacy curtains pulled..." b. 11/22/11 - "...refused skin assessment... stays in the room with door closed and privacy curtain pulled..." c. 2/4/12 - "...Resident very agitated and restless @ [at] dinner time towards staff and other residents. Resident refused to eat dinner, attempted to hit nurse and another resident... Aggressive @ times..." d. 3/20/12 - "...Aggressive towards other resident and staff..." e. 4/9/12 - "...confusion noted @ times with agitation..." f. 4/11/12 - "...resident refused this nurse's	F 250			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 250	<p>Continued From page 94</p> <p>request to perform a head to toe skin assessment today..."</p> <p>g. 4/20/12 - "...Resident stays in the room with door closed often. Resident encouraged to socialize with other residents. Agitated @ times..."</p> <p>h. 7/18/12 - "...Attempted to notify RP [responsible party]... not to give resident large sum of money in order not to buy stuff from other residents. Resident has been purchasing stuff from another residents..."</p> <p>i. 8/9/12 - "...Refused blood draw x 2..."</p> <p>j. 9/5/12 - "...Resident hit another resident in the hallway on the 1st floor. No injuries noted to either resident. Resident stated, "hell yeah I hit the motherfucker" Im [I'm] sick of that motherfucker stealing shit from everybody." I tried to knock his motherfucking ass out of the w.c. [wheelchair]." Explained to resident he can not hit other residents. Resident [#116] stated "I'm gonna beat his ass if he steals from me again... Social worker notified and here to speak with residents. MD [Medical Doctor] notified and no new orders noted..."</p> <p>Review of Resident #116's care plan dated 3/1/12 and 8/23/12 had no documented aggressive or reclusive behaviors, refusals of care, social service referrals or mental health referrals.</p> <p>Review of the social service progress (SSP) notes from January 2012 to September 2012 there were no documented aggressive or reclusive behaviors, refusals of care or mental health referrals.</p> <p>The nursing behavior assessment dated 9/21/11 had no documented behavior issues. There were</p>	F 250			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 250	<p>Continued From page 95</p> <p>no other behavior assessments documented since 9/21/11.</p> <p>The Director of Nursing and Minimum</p> <p>Mental health documented visits on 11/15/11 and 12/6/11 with no documented problems. An abnormal involuntary movement scale (AIMS) assessment was done 12/6/11 with no problems noted. There has been no AIMS completed since 12/6/11.</p> <p>The facility failed provide the necessary social services including mental health referrals which placed Resident #116 in IJ.</p> <p>4. Medical record review for Resident #43 documented an admission date of 12/22/09 with diagnoses of Vascular Dementia with Delusions, Diabetes Mellitus, Alcohol Abuse, Hypertension, Convulsions, Cerebrovascular Accident, and Left Hemiparesis. Review of the annual MDS dated 11/23/11 and the most recent quarterly MDS dated 8/1/12 documented that Resident #43 had impaired vision but did not have corrective lenses. Review of the care plan dated 11/29/11 and revised 8/7/12 documented, "...IMPAIRED VISION... 3... FOLLOW UP WITH OPHTHALMOLOGY / OPTOMETRY PHYSICIANS..." The facility was unable to provide documentation of a consult for vision services.</p> <p>During an interview in the activity room on 9/12/12 at 11:30 AM, the surveyor asked Resident #43 if he had any trouble reading. Resident #43 stated, "...when I read for a while my sight gets a little blurry..." Resident #43 was</p>	F 250			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 250	<p>Continued From page 96</p> <p>asked about glasses. Resident #43 stated, "...I could probably use some glasses..."</p> <p>During an interview in the SW's office on 9/18/12 at 11:30 AM, the SW was asked how referrals are made for a vision consult. The SW stated, "...I get with nursing, residents and family's... then I get with [named the financial service manager] from Resident Trust to see if the resident is... eligible... or if the family is willing to pay for the glasses..." The SW was asked if Resident #43 had ever had a vision consult. The SW stated, "...I will have to check..."</p> <p>During an interview in the conference room on 9/18/12 at 1:55 PM, the SW confirmed that Resident #43 had not previously had a vision consult.</p> <p>5. Medical record review for Resident #60 documented an admission date of 3/5/10 with diagnoses of Right and Left Heel Wounds, Diabetes Mellitus, Gastro Esophageal Reflux Disease, Multiple Sclerosis, Hypertension and Hypothyroidism. Review of the MDS with an ARD of 7/18/12 section B for vision was coded zero indicating no corrective lens. Review of the care area assessment (CAA) with an ARD of 7/18/12 documented, "...visual function summary notes Resident triggered D/T [due/to] impaired vision..."</p> <p>Review of a form from the "[Named eye clinic] dated 9/4/11 documented an eye exam with a prescription for glasses. Review of a form in Resident #60's medical record dated 1/11/12 documented, "...Glasses Dispensing Form..." dated 1/11/12.</p>	F 250			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 250	<p>Continued From page 97</p> <p>Review of the care plan dated 2/9/12 documented, "...IMPAIRED VISION... Approach... 3 FOLLOW UP WITH OPHTHALMOLOGY / OPTOMETRY PHYSICIANS..."</p> <p>Review of the social service progress (SSP) notes dated 9/2/10, 12/2/10 documented, "...Resident is seen as needed by...dental, eye care..."</p> <p>Observations in Resident #60's room on 9/12/12 at 3:30 PM, revealed Resident #60 wearing glasses.</p> <p>During an interview in Resident #60's room on 9/12/12 at 6:15 PM, Resident #60 was asked how long he had glasses. Resident #60 stated, "...6 or 7 months... my brother bought them for me..."</p> <p>During an interview in the conference room on 9/14/12 at 12:30 PM, the SW was asked for clarification of Resident #60's obtaining glasses. The SW validated Resident #60 came to her and told her he needed glasses and dentures at the same time. The SW stated this was sometime in October 2011. This surveyor asked the SW what the process was that was followed when a resident needed glasses or dentures. The SW stated that she checks to see if the Resident has [financial resources] and if the resident does not I notify the family they need glasses or dentures. This surveyor asked if she told this surveyor on 9/13/12 that this family did not have any money to buy the resident's glasses or dentures. The SW verified "Yes..." The SW was asked if she had resources for residents that don't have money that have needs for dental or visual exams. The SW stated, "Yes." The SW was then asked what</p>	F 250			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 250	<p>Continued From page 98</p> <p>the resources were. The SW stated she checks with local church groups and sometimes the facility will cover the expense. The surveyor asked if the facility cover these expenses [glasses/dentures]?" The SW stated, "No.." The SW was asked, "Are you aware that Resident #60 received glasses that his brother purchased in January 2011?" The SW stated, "No, the resident told me that his brother bought his glasses in April..." The SW was asked, "Did you attempt any resources to obtain glasses or dentures for Resident #60 from September 2011 through January 2012?" The SW stated "No, I did not..." The SW verified Resident #60 was not... eligible. The SW was asked if she had documented that this resident needed glasses or dentures, notified the RP or any attempts to help this resident get the items he needed. The SW stated, "No." The SW was asked, "For clarification, Resident #60 waited until May 2012 to have his teeth extracted because he was not approved through the state for [financial resources]?" The SW stated "Yes." The SW was asked, "...did you do anything to help him through your resources? The SW stated, "No.."</p> <p>6. Medical record review for Resident #63 documented an admission date of 12/3/08 with diagnoses of Diabetes Mellitus, Schizophrenia, Dementia and Dyslipidemia. Review of the MDS with an ARD of 10/31/11 section L was coded for D and F indicating obvious or likely cavity or broken natural teeth and mouth or facial pain, discomfort or difficulty with chewing. Review of the CAA Review Report dated 10/19/11 section Dental Care Summary Notes documented, "RESIDENT WITH CARIES AND DECAYED TEETH SOME WITH BLACK SEGMENTS AT</p>	F 250			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 250	<p>Continued From page 99</p> <p>GUM LINE. RESIDENT WITH COMPLAINTS OF TOOTHACHE DURING ASSESSMENT PERIOD AND WAS PLACED ON ANTIBIOTIC THERAPY. WILL PROCEED WITH WITH CARE PLANNING TO REFER TO DENTIST FOR EVALUATION AND TREATMENT AS INDICATED GIVE ANTIBIOTIC AS ORDERED AND TO MEDICATE FOR PAIN AS NEEDED FOR TOOTHACHE..."</p> <p>Observations in the dayroom on 9/10/12 at 10:30 AM, Resident #63 was was noted to have two top teeth visible with brownish stains, bottom teeth chipped and broken with brownish stains noted and need of cleaning.</p> <p>Observations in the dayroom on 9/10/12 at 3:00 PM and 4:45 PM and 9/12/12 at 8:00 AM, Resident #63's teeth needed cleaning.</p> <p>During an interview in the SW's office on 9/12/12 at 3:38 PM, the SW was asked about dental assistance for Resident #63. The SW stated, "I call [named dental office] and they put them [residents] on a list. If they are Item D eligible then the state will cover it otherwise family responsible party have to pay for it. [Named dental office] will call family and let them know cost of examination." The SW proceeded to place a call to the dental office to find out when Resident #63 was last seen by the dentist. Resident #63 was last seen by the dentist in 2007, which was prior to admission to the facility. The SW further stated, "She's [referring to Resident #63] is not... eligible so her daughter would have to pay for it and she don't like to spend money." The surveyor then asked the SW about other sources to assist with dental needs of the resident. The SW stated, "I don't have any</p>	F 250			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 250	<p>Continued From page 100 other sources..."</p> <p>During an interview in the conference room on 9/12/12 at 4:00 PM, the Director of Nursing (DON) was asked who was responsible for dental appointments for residents. The DON stated, "Whoever did the CAA should have told nurse on unit so they could notify Social Services and she will in turn check with [named dental provider] to see if they can see her if not then we would check for our services to see who can see her."</p> <p>During an interview in the Administration office on 9/12/12 at 4:20 PM, Nurse #3 was asked about a dental consult for Resident #63. Nurse #3 stated, "I put it [dental consult] on the CAA. When we have the care plan meeting, I normally if SW in there will tell her then. If not in care plan meeting will call her [SW] and let her know."</p> <p>During an interview on the administration hall on 9/13/12 at 5:50 PM, the SW stated, "She doesn't have [financial resources] so her daughter will have to pay for any dental service and I know her she doesn't like to spend any money."</p> <p>During an interview in the conference room on 9/14/12 at 1:15 PM, the DON was asked about dental appointments for residents. The DON stated, "[Named Social Worker] makes the appointment she checks to see if they have [financial resources]. If not... eligible and family can't pay then the facility has to take care of it..."</p> <p>7. Medical record review for Resident #68 documented an admission date of 1/22/10 with diagnoses of Cerebrovascular Accident, Hemiplegia, Hypertension, Musculoskeletal</p>	F 250			

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F 250	<p>Continued From page 101</p> <p>Disorder of the Neck, Osteoarthritis, Diabetes Mellitus, Gastroenteritis, Renal Insufficiency, Degenerative Joint Disease, Callosities, Frequent Urination, Hypocholesterolemia, and Epilepsy.</p> <p>Nurses notes documented the following:</p> <p>a. 5/11/12 at 11:00 AM - "...found on second floor pulling down linen... staff said that he urinated on linen... Pt [patient] states "I was looking for a diaper, I didn't do that. I just pee on myself... told him to ask staff on his floor... understands and won't do it again..."</p> <p>b. 5/17/12 at 11:00 AM - "...Activity reported that resident had been informed multiple times to stop going in smoke... and going out doors and coming down handicap ramp... he just rode away from me in his wheelchair..."</p> <p>c. 7/11/12 at 11:00 AM - "...taking liners out of garbage cans..."</p> <p>d. 8/14/12 at 5:00 AM - "Resident continually taking other residents belongings personal items and clothing... going to other units taking or stealing items... going through personal things..."</p> <p>Review of the SSP for 2012 do not address the behaviors as noted in the nurses notes.</p> <p>8. Medical record review for Resident #104 documented an admission date of 8/2/11 with diagnoses of Schizophrenia, Dementia, Diabetes Mellitus, Seizure Disorder and Tardive Dyskinesia and a readmission date of 5/16/12 with new diagnoses of Subdural Hematoma and Percutaneous Endoscopy Gastrostomy Tube. Review of the nurses notes throughout the resident's stay documented multiple episodes of throwing and smearing bodily wastes and resisting care. There is no documentation in the</p>	F 250			

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NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 250	<p>Continued From page 102 SSP of behaviors.</p> <p>9. Medical record review for Resident #124 documented an admission date of 3/23/12 with diagnoses of Atrial Fibrillation, Diabetic Mellitus, Bradycardia, Hypertension, Dementia, Agitation, Sexual Inappropriate Behavior, Alcohol Abuse, Muscle Weakness, Symbolic Dysfunction and Dysphagia Oropharyngeal Phase. Review of the MDS with an ARD of 3/29/12, 4/2/12, 4/10/12 and 6/21/12 documented in Section B1000 assessed the resident's vision is "...Impaired - sees large print, but not regular print in newspapers / books..."</p> <p>Review of the CAA review report dated 3/29/12 documented, "Vision... Impaired... Resident triggered because he has impaired vision. His ability to see only in adequate light. Resident stated during interview that he does not have his glasses that were missing before admission to the facility. We will care plan to anticipate the resident's needs. We will also notify the ophthalmology department for new glasses, if possible."</p> <p>Review of the care plan dated 4/5/12 and updated 6/27/12 documented, "...Alteration in visual function r/t [related to] impaired vision... will maintain optimal level of function... follow up with ophthalmology/optometry physicians..."</p> <p>The facility was unable to provide documentation that a vision referral had been made.</p> <p>Observations in Resident #124's room on 9/11/12 at 9:50 AM, revealed Resident #124 was not wearing glasses.</p>	F 250			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 250	Continued From page 103 During an interview in Resident #124's room on 9/12/12 at 5:00 PM, Resident #124 was asked if he had ever had his eyes tested or if he had ever worn glasses. Resident #124 stated, "They [glasses] were stolen at the last place he was at and that he probably needed to be seen by an eye doctor for a new pair of glasses." During an interview in the MDS office on 9/14/12 at 9:00 AM, the SW was asked about Resident #124 having impaired vision at the time of admission, having no glasses and why this needed care was not addressed. The SW stated, "...I don't know. It's the resident or family member that will ask for vision consult, that's how I get notified that the resident needs glasses. Before [named school of optometry] comes out and sees them, they have to be ensured of payment... Department of Human Services determines eligibility, the state will pay for the eye exam and glasses, if not, I will have to get in touch with the family..." During an interview in the MDS office on 9/14/12 at 10:30 AM, Nurse #3 was asked if Resident #124 had impaired vision. Nurse #3 confirmed that the resident had been assessed as having impaired vision on the comprehensive assessment at the time of admission. During an interview in business office on 9/14/12 at 10:43 AM, the Financial Services Manager (FSM) was asked if Resident #124 had been referred to her to determine... eligibility due to a request for a vision referral. The FSM stated, "...No, he has not. He is Medicaid and does receive a social security check, so that would	F 250			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 250	Continued From page 104	F 250			
F 252 SS=E	<p>make him... eligible..."</p> <p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, it was determined the facility failed to ensure residents had a fine dining experience during 2 of 2 (9/10/12 and 9/12/12) dining observations.</p> <p>The findings included:</p> <p>1. Observations in the social dining room on 9/10/12 at 5:10 PM, revealed the residents were served their supper meal on trays.</p> <p>Observations in the 1st Magoffin dining room on 9/10/12 at 5:25 PM, revealed the residents were served their supper meal on trays. One male resident had his head laying on the table with water spilled all over table. Five random residents were waiting for their meal while all other residents were eating.</p> <p>Observations in the 1st Magoffin dining room on 9/10/12 at 5:30 PM, revealed the television was on with the volume high and a radio simultaneously playing with the volume high.</p> <p>2. Observations in the social dining room on</p>	F 252			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 252	Continued From page 105 9/12/12 at 12:30 PM, revealed the residents were served their lunch meal on trays.	F 252			
F 253 SS=F	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to provide housekeeping and effective maintenance services to maintain a sanitary, orderly and comfortable environment as evidenced by baseboards peeling from the wall and torn baseboards in bathrooms, scuff marks on walls, dust on personal fan blades, cracked and missing tiles, torn curtains, curtains with holes, missing hooks and curtains with brown stains, non working sink faucets, leaking faucets, non working air condition (AC) units with broken panels and missing dials, non working over bed lights, window curtains with torn hems, wet, dirty and brown stain towels in a sink on 3 of 3 (1st Magoffin, 2nd Magoffin and 1st McRee) units The facility's failure to provide effective maintenance and housekeeping services to maintain a sanitary, orderly and comfortable environment resulted in substandard quality of care. The findings included: 1. Review of the facility's daily housekeeping policy documented, "...floors cleaned and mopped, basin cleaned, baseboards clean, vents	F 253			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 253	<p>Continued From page 106</p> <p>cleaned and dust free, window sills clean and dust free, window/privacy curtains clean and in good repair, AC unit clean and dust free, all furniture dusted, paper products replenished, mirror cleaned, trash emptied and replace liners, bathroom cleaned, replenish soap.</p> <p>2. Observations during the initial tour of 1st Magoffin on 9/10/12 beginning at 9:45 AM revealed the following:</p> <p>a. Room 101 - Walls scuffed with black marks.</p> <p>b. Room 103 - Walls scuffed with paint off, bath pan in floor with dirty water.</p> <p>c. Room 104 - Soiled wheelchair with one missing arm. Trash on the floor in room.</p> <p>d. Room 105 - Small metal bedside table with large amount of paint missing with rusty brownish areas showing. Walls scuffed with black marks with paint off, sheetrock corners scuffed with paint off.</p> <p>e. Room 107 - Lock on closet door with a screw in it with the lock hanging loosely.</p> <p>f. Room 108 - Heating unit in bathroom with exposed installation on pipe to floor under unit in front of commode and spider webs over the sink.</p> <p>g. Room 109 - Strong urine odors.</p> <p>h. Room 110 - Strong urine odors, AC leaking water on the floor, moldy appearance, two gnats flying around the bed, bedside commode with cracked plastic arms patched with tape and dirty tape hanging from broken arms.</p> <p>i. Room 111- No handle on the sink faucet.</p> <p>j. Room 112 - Broken floor tiles missing between the bed and window.</p> <p>k. Room 115 - Black scars on walls and outside corners of door frame.</p> <p>l. Room 117 - Walls with black scuffed marks.</p> <p>m. Room 118 - No bedside tables in the room.</p>	F 253			

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F 253	Continued From page 107 n. Room 119 - the light above the sink was not functioning and the light above the A bed was flickering on the bottom. The light above B bed was not working. o. Room 120 - Walls with peeling and chipped paint between the bed and window, missing call light reset button, broken commode with the top of the tank off sitting on the seat, handle for the commode missing, water to commode turned off, toilet paper holder pulled out of the wall and hanging on grab bar, dust in vents and on the top of AC unit. p. Room 121 - Fan cover missing from in front of the fan, dresser drawer off the track and hanging down by the bed. q. Room 123 - Black scuff marks on walls. 3. Observations during initial tour 2nd Magoffin on 9/10/12 beginning at 10:00 AM revealed the following: a. Room 201 - Walls scuffed. b. Room 203 - Broken and missing tile under the bed. c. Room 204 - Feeding pump with light brown spillage noted on top of it and strong urine odors. d. Room 205 - Strong urine odors and a strong sour odor in the room and penetrating to the hallway. e. Room 206 - Privacy curtains off hooks, a roach in the room and scuffed walls. f. Room 207 - Privacy curtains with holes. g. Room 208 - Scuffed marks on the wall, faucet to sink will not turn on, missing privacy curtains from foot of bed #1, bed #2 with torn privacy curtain and personal fan with dust on the blades. h. Room 211 - Strong urine odor and sticky floor . i. Room 212 - Floor sticky. j. Room 214 - Strong urine odor in the bathroom,	F 253			

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F 253	<p>Continued From page 108</p> <p>toothbrush laying uncovered on the sink, a fly and gnat flying around in room.</p> <p>k. Room 215 - Strong urine odor in room and bathroom room, privacy curtains off the hooks, faucet to the sink will not turn on/off (knobs will turn all the way around), a blanket on the floor near the sink and personal fan with dust on the blades.</p> <p>l. Room 216 - Loose baseboards in bathroom, sink dripping and will not turn off and light over bed will not turn on or off.</p> <p>m. Room 217 - Brown dried stains on the privacy curtains.</p> <p>n. Room 219 - Strong urine odor in the room and bathroom, peeling baseboards in the bathroom, privacy curtains off the hooks, brown color stains on the curtains and scuffed walls.</p> <p>o. Room 220 - Seat of chair cracked with foam exposed, privacy curtains off the hook and urinal containing yellow liquid sitting on the floor.</p> <p>p. Room 221 - Strong urine odor in the bathroom with a sticky floor.</p> <p>During an interview on 2nd Magoffin on 9/14/12 at 10:15 AM, the Vice-President and Maintenance Supervisor verified the presence of odors in room 205 and of urine odors on the 2nd Magoffin hallway.</p> <p>4. Observations during the initial tour of 1st McRee on 9/10/12 beginning at 9:45 AM, revealed the following:</p> <p>a. Room 401 - Wheelchair with dirty residue buildup on the wheels and torn seat.</p> <p>b. Room 403 - Mattress on the bed had a large brown stained covering the middle section of the mattress, three gnats were crawling on the mattress and swarming around an area of</p>	F 253			

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NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 253	Continued From page 109 black/clumped dried substance in the fold of the mattress covering, foul smelling odor from the mattress and the mattress entire middle section was sunken in. c. Room 406 - Room was cluttered with a strong urine odor. d. Room 408 - Bed #1's pillow had stuffing hanging out, strong urine odor coming from the closet, bed #2 had a cracked pillow cover, dirty over-bed table, floor dirty, not swept or moped. e. Room 409 - Trash on the floor. f. Room 410 - Window open with dust on window seal, personal fan with dust on blades, sink with no hot water, armless chair with smell of urine and chipped tile under the sink. g. Room 411 - Bed #2's flat sheet with brown circle in the middle, strong urine odor in the room, a large yellowish wet area on the floor at the head of the bed, over-bed table sticky and dirty with dried food, an uncovered syringe laying on the table, urinal with yellow liquid sitting on the over-bed table, ceiling tile pushed up in the ceiling over Bed #3 and wall covering pulled from the wall between the window and Bed 3. h. Room 414 - Strong urine odor in room and the cover was torn away from the ceiling light. i. Room 415 - Over-bed table dirty and sticky. j. Room 417 - Strong urine odors in the room. k. Room 419 - Chair with missing vinyl on arms with stuffing exposed, faucet running in sink and will not shut off l. Room 421 - Twelve to 14 winged insects crawling on a wet brown stained towel in the sink, no mirror over the sink with a piece of cardboard over the area. m. Room 424 - Sink faucet dripping and wall scuffed with back marks.	F 253			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 253	Continued From page 110 During an interview on 1st McRee on 9/12/12 at 7:40 AM, certified nursing assistant (CNA) #12 stated, "11-7 shift is suppose to deep clean, but they don't..." CNA #12 was asked if the wheelchair was clean she looked at the wheelchair and stated, "No it's dirty. It should have been cleaned." During an interview in room 403 on 9/14/12 at 12:50 PM, the Director of Nursing (DON) was asked what the brown discoloration and dried substance on the covering of the mattress was. The DON stated, "I don't know. The mattress is old." The DON verified the mattress need replacing. During an interview in room 414 on 9/17/12 at 10:00 AM and 11:10 the maintenance supervisor stated, "The odor is better than it was and he would get them to clean the room." 5. During an interview on 3rd Magoffin on 9/14/12 at 10:00 AM, the maintenance supervisor was asked how cleaning is done in the resident rooms to control odors and if the resident rooms are terminally cleaned. The maintenance supervisor stated, "They [nursing staff] watch that every day and tell me when rooms need cleaning..." The maintenance supervisor confirmed they do pull furniture out of the rooms and clean but do not take the residents clothes out of the closets to clean. The maintenance supervisor did not answer how often terminal cleaning was done. Refer to F465 F and F469F for further enviornmental issues cited.	F 253			
F 254	483.15(h)(3) CLEAN BED/BATH LINENS IN	F 254			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/20/2012
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F 254 SS=F	Continued From page 111 GOOD CONDITION The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined the facility failed to ensure bed linens were clean and in good condition on 3 of 3 (1st McRee, 1st Magoffin and 2nd Magoffin) units. The findings included: 1. Observations during the initial tour of 1st McRee on 9/10/12 beginning at 9:45 AM, revealed the following: a. Room 402, sheets thin. b. Room 403, torn sheet on bed. c. Room 406, pillowcase dingy. d. Room 407, pillow brown in color with cracks noted in pillow no pillowcase. e. Room 410, pillowcase dirty with stains. f. Room 411-2 bedspread with four yellowish-brownish stains. g. Room 102, pillowcase was dingy. h. Room 110, linens thin and dingy. i. Linen cart with a threadbare cover. j. Linen room with 10 dingy flat sheets, 3 dingy fitted sheets, 14 dingy towels and 7 thin gowns. Observations of the linen room on 1st McRee on 9/11/12 at 8:30 AM, revealed the following: a. 20 fitted sheets, thin and dingy. b. 4 hand towels. c. 5 flat sheets, thin and dingy. d. 7 dingy rough thin towels.	F 254		

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 254	<p>Continued From page 112</p> <p>e. 4 threadbare gowns. f. 17 blue pads. There were no pillowcases in the linen room. There were 29 residents residing on 1st McRee.</p> <p>During an interview in the linen room on 1st McRee on 9/11/12 at 8:30 AM, certified nursing assistant (CNA) #9 was asked about linen supply. CNA #9 stated, "This is all [linens] I have for the day."</p> <p>During an interview on 1st McRee hall on 9/12/12 at 6:40 PM, CNA #12 was asked if there were any pillowcases on the cart. CNA #12 stated, "No Ma'am I don't." CNA #12 was then asked if she had trouble getting pillowcases. CNA #12 stated, "We get them sometimes."</p> <p>During an interview in the conference room on 9/13/12 at 11:15 AM, Nurse #10 was asked about linen supply. Nurse #10 stated, "On 11-7 shift there is no linen to make rounds, 3-11 shift using the 11-7 shift linen. Linens come in spurts and bits..."</p> <p>Observations on 1st McRee in room 401 on 9/14/12 at 10:24 AM, revealed CNA #3 washed the resident's face using a corner of a hand towel. CNA #3 stated, "We don't have wash cloths. We have these [towels]."</p> <p>During an interview in the hallway of 1st McRee on 9/17/12 at 10:00 AM, CNA #1 was asked if there were linens to restock the linen cart. CNA #1 stated, "I'm going to fill my cart with what we have." CNA #1 was asked if there were pillow cases. CNA #1 stated, "No, we don't have pillow cases."</p>	F 254			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 254	<p>Continued From page 113</p> <p>During an interview on 1st McRee outside room 404 on 9/17/12 at 10:00 AM, CNA #2 was asked if there were any pillowcases on the linen cart. CNA #2 stated, "No Ma'am."</p> <p>2. Observations during the initial tour of 1st Magoffin on 9/10/12 beginning at 9:45 AM, revealed three linen carts with no wash cloths or pillow cases.</p> <p>Observations of the clean linen cart on 1st Magoffin on 9/12/12 at 10:18 AM, revealed there were no pillowcases available for use.</p> <p>There were 37 residents residing on 1st Magoffin.</p> <p>3. Observations during the initial tour of 2nd Magoffin on 9/10/12 beginning at 10:00 AM, revealed the following:</p> <ul style="list-style-type: none"> a. Room 201, Resident #6's gown was threadbare and the bed linens were thin. Resident #6's skin could be seen through the threadbare gown. b. Room 204, numerous holes in the blanket. c. Room 206, fitted sheet thin, pillowcase dingy. d. Room 210, fitted sheet thin. e. Room 211, fitted sheet thin. f. Room 212, fitted sheet threadbare, no pillowcase on pillow. g. Room 215, fitted sheet thin. h. Room 221, thin fitted sheet, no pillowcase on pillow, top sheet thin with stains. i. Room 216, top sheet thin and blanket was wet with yellow stains. j. Room 217, no pillowcase on the pillow. <p>Observations in Resident #6's room (2nd</p>	F 254			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 254	Continued From page 114 Magoffin) on 9/10/12 at 11:15 AM, revealed Resident #6's gown was threadbare and the bed linens were thin. Resident #6's skin could be seen through the threadbare gown. Observations in Resident #6's room (2nd Magoffin) on 9/10/12 at 5:10 PM, Resident #6 had a very thin sheet over her. During a phone interview in the conference room on 9/12/12 at 8:50 AM, the family member of Resident #6 stated, "She [Resident #6]... had holes in her garments... sheets were threadbare..." Observations of the linen carts on 2nd Magoffin on 9/11/12 at 8:20 AM, revealed the following: Linen cart #1 had a. 9 blue pads. b. 6 hand towels. c. 4 bath towels, dingy and rough. d. 7 thin threadbare gowns. e. 4 thin flat sheets. f. 7 thin dingy fitted sheets. Linen cart #2 had a. 2 blue pads. b. 1 gown thin and threadbare. c. 5 towels, dingy and rough. d. 1 hand towel. e. 4 thin fitted sheets. f. 10 flat thin sheets and one sheet had a burnt hole. There were no pillowcases on Cart #1 or Cart #2. There were 31 residents residing on 2nd Magoffin.	F 254			
F 256 SS=D	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS	F 256			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 256	<p>Continued From page 115</p> <p>The facility must provide adequate and comfortable lighting levels in all areas.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there was adequate lighting in 2 of 3 (1st Magoffin dayroom and 2nd Magoffin dayroom) dayrooms and in 3 of 68 (Rooms 119, 216 and 414) resident rooms.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Observations in the 1st Magoffin dayroom on 9/10/12 beginning at 10:00 AM, revealed two of the five overhead lights were not functioning. Observations in the 2nd Magoffin dayroom on 9/10/12 at 5:25 PM, on 9/12/12 at 9:50 AM, and on 9/18/12 at 11:10 AM, revealed there was two ceiling light fixtures and only one fixture was functioning. The dayroom was dimly lighted. <p>During an interview in the 2nd Magoffin dayroom on 9/20/12 at 8:45 AM, the maintenance verified there was a problem with the lights.</p> <ol style="list-style-type: none"> Observations in room 119A on 9/17/12 at 9:50 AM, revealed the light above the sink was not functioning, the light above the bed was flickering on the bottom and there was very small amount of light from the top. Observations in room 119B on 9/17/12 at 9:50 AM, revealed the light above the bed was not working. 	F 256			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 256	Continued From page 116 4. Observations during initial tour of 2nd Magoffin on 9/10/12 beginning at 10:00 AM revealed the light would not turn off and light and the light over the bed will not turn on or off. 5. Observations in room 414 on 9/10/12 at 10:00 AM, revealed the cover was torn away from the ceiling light.	F 256			
F 258 SS=D	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, it was determined, the facility failed to ensure sound levels were comfortable in 2 of 3 (1st Magoffin dining room and 2nd Magoffin dayroom) dining/dayrooms. The findings included: 1. Observations in the 1st Magoffin dining room on 9/10/12 at 5:30 PM, revealed the television was on with the volume high and a radio simultaneously playing with the volume high. 2. Observations in the 2nd Magoffin dayroom on 9/17/12 at 10:38 AM, revealed the television was on with the volume high and a "Boom Box" was simultaneously playing with the volume high.	F 258			
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the	F 278			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 278	<p>Continued From page 117 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, observation and interview, it was determined the facility failed to accurately assess residents with visual deficits for 1 of 27 (Residents #60) sampled residents of the 38 residents included in the Stage 2 review.</p> <p>The findings included:</p>	F 278			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 278	Continued From page 118 Medical record review for Resident #60 documented an admission date of 3/5/10 with diagnoses of Dementia, Diabetes Mellitus, Hypertension, Wounds Bilateral Heels and Seizures. Review of the annual Minimum Data Set (MDS) with an assessment reference (ARD) of 2/3/12 documented impaired vision with no corrective lenses used. Review of the quarterly MDS dated 7/18/12 documented impaired vision with no corrective lenses used. Resident #60 received glasses on January 11, 2012. The MDS dated 2/3/12 and 7/18/12 were inaccurate for vision. Observation in Resident #60's room on 9/12/12 at 3:30 PM, revealed Resident #60 wearing glasses. During an interview at 1st McRee nurses station on 9/17/12 at 10:25 AM, Nurse #3 was asked to review the MDS dated 7/18/12 and show this surveyor where to locate the assessment for Resident #60's glasses. Nurse #3 stated, "It's not there." Nurse #3 was then asked should the corrective lens section be coded for glasses if the resident wears glasses. Nurse #3 stated, "Yes."	F 278			
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 279			

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

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F 279	<p>Continued From page 119 assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, it was determined the facility failed to develop a care plan that addressed side rails, medications, range of motion (ROM), hydration, vision, laboratory (lab) tests, nutrition and behaviors for 7 of 31 (Residents #14, 23, 24, 27, 68, 104 and 116) sampled residents of the 38 residents included in the stage 2 review.</p> <p>The findings included:</p> <p>1. Medical record review for Resident #14 documented an admission date of 6/16/09 with diagnoses of Diabetes Mellitus, Hypertension, Status Post Cerebrovascular Accident, Obesity, Bipolar Disorder, Constipation and Schizoaffective Disorder-Bipolar Type. Review of the Physician's orders dated 9/1/12 documented, "...SIDERAILS UP X [times] 2 FOR BED MOBILITY & [and] POSITIONING..." Review of the care plan dated 8/22/12 did not address the use of siderails. There was no care plan for the use of siderails.</p>	F 279			

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F 279	<p>Continued From page 120</p> <p>Observations in Resident #14's room on 9/12/12 at 8:20 AM, 11:20 AM and 4:00 PM, revealed Resident #14 in bed with side rails up times 2.</p> <p>Observations in Resident #14's room on 9/13/12 at 8:18 AM, revealed Resident #14 in bed with siderails up times 2.</p> <p>Observations in Resident #14's room on 9/17/12 at 10:40 AM, revealed Resident #14 was in bed with siderails up times 2.</p> <p>During an interview in the minimum data set (MDS) office on 9/13/12 at 3:25 PM, Nurse #3 was asked how often are siderail assessments completed and who completes them. Nurse #3 stated, "...I think they are done quarterly and the nurses do them..."</p> <p>2. Medical record review for Resident #23 documented an admission date of 1/29/99 with diagnoses of Subarachnoid Hemorrhage, Hemiplegia, Diabetes, Dementia, Hypertension and Seizure Disorder and a readmission date of 9/10/12 with a new diagnosis of Dilantin Toxicity. Review of physician's orders dated 9/10/12 documented, "...Enoxaparin 40 mg [milligrams] inject @ [at] 1200 [12:00 PM] daily (Lovenox)..." Review of the care plan dated 7/24/12 did not address the resident's use of Lovenox.</p> <p>3. Medical record review for Resident #24 documented an admission date of 7/19/12 with diagnoses of Diabetes Mellitus, Peripheral Vascular Disease, Hypertension, Congestive Heart Failure, Urinary Tract Infection, Cerebrovascular Accident, and Dementia with</p>	F 279			

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F 279	<p>Continued From page 121</p> <p>Behaviors. Review of the MDS with an assessment reference date (ARD) of 4/12/12 and updated 7/5/12, section G-A and B were coded as "1" indicating the resident had limitations in range of motion (ROM) of upper and lower extremities on one side. Review of the care plan dated 7/12/12 did not address the resident's limitations in range of motion (ROM).</p> <p>Observations in the dayroom on 9/10/12 at 10:30 AM, revealed Resident #24 seated in a wheelchair with his left arm in a flexed position.</p> <p>Observations in the 2nd Magoffin hallway on 9/10/12 at 4:50 PM and on 9/11/12 at 8:45 AM, revealed Resident #24 seated in a wheelchair with his left arm in a flexed position.</p> <p>During an interview at the 2nd Magoffin nurses' station on 9/10/11 at 11:30 AM, Nurse #8 confirmed that Resident #24 did not wear a splint and was not receiving ROM exercises.</p> <p>4. Medical record review for Resident #27 documented an admission date of 7/20/01 with diagnoses of Subdural Hematoma, Left Sided Temporal Skull Defect, Seizures, Gastro Esophageal Reflux Disorder and Anxiety. Review of physician's orders dated 7/25/12 documented, "...Assess for clinical S/S [signs and symptoms] of dehydration with physician notification and documentation in nurses notes or negative findings..." Review of nursing notes and flowsheets dated January 2012 through August 2012 documented no positive or negative findings regarding dehydration. Review of the care plan dated 8/5/12 did not address hydration.</p>	F 279			

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F 279	<p>Continued From page 122</p> <p>Observations in the 1st Magoffin hallway on 9/11/12 at 2:15 PM, revealed Resident #27 carrying an ice pitcher attempting to get ice from the ice chest.</p> <p>During an interview in Resident #27's room on 9/11/12 at 2:30 PM, Resident #27 ws asked if sufficient fluids were provided for residents between meals. Resident #27 stated, "...we have to go out and ask for ice... they [staff] don't bring it in..."</p> <p>5. Medical record review for Resident #68 documented an admission date of 1/22/10 with diagnoses of Cerebrovascular Accident, Hemiplegia, Hypertension, Musculoskeletal Disorder of the Neck, Osteoarthritis, Gastroenteritis, Renal Insufficiency, Diabetes Mellitus, Hypocholesterolemia, Callosities, Degenerative Joint Disease, Frequent Urination, and Epilepsy.</p> <p>Review of nurses notes documented the following:</p> <p>a. 5/11/12 at 11:00 AM - "...found on second floor pulling down linen... "staff" said that he urinated on linen... Pt [patient] states "I was looking for a diaper, I didn't do that. I just pee on myself... told him to ask staff on his floor... understands and won't do it again..."</p> <p>b. 5/17/12 at 11:00 AM - "Activity reported that resident had been informed multiple times to stop going in smoke... and going out doors and coming down handicap ramp... he just rode away from me in his wheelchair..."</p> <p>c. 7/11/12 11:00 AM - "...taking liners out of garbage cans..."</p> <p>d. 8/14/12 5:00 AM - "Resident continually taking</p>	F 279			

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F 279	<p>Continued From page 123</p> <p>other residents belongings personal items and clothing... going to other units taking or stealing items... going through personal things..."</p> <p>Review of the care plan dated 12/27/11 and updated 3/20/12, 6/12/12 and 9/4/12 did not address Resident #68's behaviors.</p> <p>6. Medical record review for Resident #104 documented an admission date of 8/2/11 with diagnoses of Schizophrenia, Dementia, Diabetes Mellitus, Seizure Disorder and Tardive Dyskinesia. A readmission date of 5/16/12 with a new diagnosis of Subdural Hematoma and Percutaneous Endoscopy Gastrostomy tube. Review of the nurses notes dated September 2011 through June 2012 documented multiple episodes of throwing and smearing bodily wastes and resisting care. There was no documentation on the care plan that addressed these behaviors.</p> <p>7. Medical record review for Resident #116 documented an admission date of 9/8/11 with diagnoses of Alzheimer's Dementia, Aggressive Behaviors, Coronary Artery Disease, Diabetes Mellitus, Hypertension, and Congestive Heart Failure. Review of the MDS with an assessment reference date (ARD) of 3/1/12 section E-Behaviors, E0200-Behavioral Symptoms-Presence and Frequency was coded as 1 indicating presence of physical behavioral symptoms directed toward others occurring 1 to 3 days. Section E0800-Rejection of Care-Presence and Frequency was coded as 2 indicating this behavior had occurred 4 to (-) 6 days, but less than daily. Review of the MDS with an ARD of 8/17/12 section E-Behaviors, E0800 Rejection of Care-Presence and Frequency was coded as 1</p>	F 279			

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F 279	Continued From page 124 indicating this behavior occurred 1-3 days. Review of nurses notes documented the following: a. 10/28/11 - "...refused dinner... refuses skin assessment by staff... stays in room with door shut and privacy curtains pulled..." b. 11/22/11 - "...refused skin assessment... stays in the room with door closed and privacy curtain pulled..." c. 2/4/12 - "...Resident very agitated and restless @ [at] dinner time towards staff and other residents. Resident refused to eat dinner, attempted to hit nurse and another resident... Aggressive @ times..." d. 3/20/12 - "...Aggressive towards other resident and staff..." e. 4/9/12 - "...confusion noted @ times with agitation..." f. 4/11/12 - "...resident refused this nurse's request to perform a head to toe skin assessment today..." g. 4/20/12 - "...Resident stays in the room with door closed often. Resident encouraged to socialize with other residents. Agitated @ times..." h. 7/18/12 - "...Attempted to notify RP [responsible party]... not to give resident large sum of money in order not to buy stuff from other residents. Resident has been purchasing stuff from another residents..." i. 8/9/12 - "...Refused blood draw x 2..." j. 9/5/12 - "...Resident hit another resident in the hallway on the 1st floor. No injuries noted to either resident. Resident stated, "hell yeah I hit the motherfucker" Im [I'm] sick of that motherfucker stealing shit from everybody." I tried to knock his motherfucking ass out of the w.c.	F 279			

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

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FORM APPROVED
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F 279	Continued From page 125 [wheelchair]." Explained to resident he can not hit other residents. Resident [#116] stated "I'm gonna beat his ass if he steals from me again... Social worker notified and here to speak with residents. MD [Medical Doctor] notified and no new orders noted..."	F 279			
F 280 SS=E	Review of Resident #116's care plan dated 3/1/12 and 8/23/12 had no documented aggressive or reclusive behaviors or refusal of care. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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 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 medical record review, review of	F 280			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 280	<p>Continued From page 126</p> <p>incident reports, observation, and interview, it was determined the facility failed to revise the care plan for falls and siderails for 2 of 31 (Residents #23 and 82) sampled residents reviewed of 38 residents included in the stage 2 review.</p> <p>The findings included:</p> <p>1. Medical record review for Resident #23 documented an admission date of 1/29/99 with diagnoses of Subarachnoid Hemorrhage, Hemiplegia, Diabetes, Dementia, Hypertension and Seizure Disorder and a readmission date of 9/10/12 with a new diagnosis of Dilantin Toxicity.</p> <p>Review of incident reports documented the following:</p> <p>a. 8/31/12 - "...resident noted to have fallen in hallway out of w/c [wheelchair] onto floor..."</p> <p>b. 9/3/12 - "...resident found on floor in room... resident stated he fell while getting out of w/c because he felt weak... Abrasion noted to R [right] side of lip..."</p> <p>c. 9/4/12 - "...resident found on floor in an upright position... in dayroom bathroom... he stated "I was getting off commode trying to sit in wheelchair and lost my balance... c/o [complained of] headache... swollen red area noted on R side of face... treatment: Emergency Dept. [Department]..."</p> <p>d. 9/5/12 - "...Resident was found outside of building... laying flat on back with a swollen lip and abrasions to R side of face, knee and shoulder... treatment: Emergency Dept..."</p> <p>Review of the nurses notes documented the following:</p> <p>a. 9/10/12 at 11:30 AM - "...Received back to</p>	F 280			

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F 280	<p>Continued From page 127 facility from [named hospital]..." 9/10/12 at 5:30 PM - "...Resident found on floor in activities bathroom..."</p> <p>Review of the care plan dated 5/1/12 had no updates documented or new interventions after the falls that occurred on 8/31/12, 9/3/12, 9/4/12, 9/5/12 and 9/10/12 after the hospital return.</p> <p>2. Medical record review for Resident #82 documented an admission date of 1/5/11 with diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus Type I, Hypertension, Chronic Renal Disease, Bipolar Disorder, Hypothyroidism, Gout, Obesity, and Defiant Behavior. Review of a physician's order dated 8/1/12 documented, "...SR [siderail] up x [times] 2 for positioning & [and] bed mobility..." Review of the siderail assessment dated 3/25/12 documented, "...Side rails are indicated and serve as enablers to promote independence..." Review of the care plan dated 6/20/12 did not address the use of siderails for Resident #82.</p> <p>Observations in Resident #82's room on 9/10/12 at 5:16 PM and on 9/13/12 at 9:35 AM, revealed the resident lying in bed with the 3/4 length side rails up on both sides of the bed.</p> <p>Observations in Resident #82's room on 9/13/12 at 9:35 AM, revealed Resident #82 lying in bed with the 3/4 length side rails up on both sides of the bed.</p> <p>During an interview at the 1st Magoffin nurses' station on 9/19/12 at 3:53 PM, Nurse #2 was asked if siderails were used for Resident #82.</p>	F 280			

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

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F 280	Continued From page 128 Nurse #2 stated, "Yes, every time I take care of her the rails are up. She uses them to hold to when she is turned."	F 280			
F 282 SS=J	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on policy review, review of incident reports, pharmacy review, medical record review, observation, and interview, it was determined the facility failed to ensure care plan interventions were followed for laboratory, dental, pressure ulcer, nutrition, rehabilitation, activities of daily living (ADL), accident prevention, restraints, unnecessary medications, range of motion (ROM), oxygen (O2), vision and/or falls for 12 of 31 (Residents #23, 81, 82, 74, 21, 28, 43, 63, 84, 104, 118 and 124) sampled residents of the 38 residents included in the stage 2 review. The facility failed to follow care plan interventions for fall preventive program; obtain, monitor and report abnormal laboratory levels as ordered, and perform wound care and ADL care as ordered which placed Residents #23, 81, 82 and 74 in immediate jeopardy (IJ). The facility was cited with IJ at F282 at a scope and severity of "J" following administrative review on 10/1/12. The facility was notified of this IJ per phone conversation on 10/3/12 at 8:45 AM and via fax on 10/3/12 at 9:31 AM. This IJ is considered present and ongoing.	F 282			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 282	Continued From page 129 The findings included: 1. Review of the facility's "Care Plan" policy documented, "Each resident will have an individualized Care Plan that is developed by the interdisciplinary team with input from the resident and family. All nursing personnel will refer to the Care Plan when providing care..." Review of the facility's "LAB [laboratory] POLICY" documented, "...PURPOSE: To provide adequate interventions to maintain stable health conditions... D. The LPN [Licensed Practical Nurse] will review lab [laboratory] results and contact the Md [Medical Doctor]. The LPN will document in the nurse's note whom, when and what information provided to MD with notation of any orders... L. The MD is to be notified of all critical lab values immediately. M. If no response from MD in (1) hour, the Nursing Supervisor is to be called. If still no response the DON [Director of Nursing] is to be notified..." 2. Medical record review for Resident #23 documented an admission date of 1/29/99 with diagnoses of Subarachnoid Hemorrhage, Hemiplegia, Diabetes, Dementia, Hypertension and Seizure Disorder and a readmission date of 9/10/12 with a new diagnosis of Dilantin Toxicity. Review of the care plan dated 5/1/12 and reviewed 7/24/12 documented, "...FALL RISK R/T [related to] HISTORY AND UNSTEADY GAIT... Place resident on fall prevention program... Potential for Seizure Activity r/t Hx [history] of Seizure Disorder..."	F 282			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 282	<p>Continued From page 130</p> <p>Review of incident reports documented the following:</p> <p>a. 8/31/12 - "...resident noted to have fallen in hallway out of w/c [wheelchair] onto floor..."</p> <p>b. 9/3/12 - "...resident found on floor in room... resident stated he fell while getting out of w/c because he felt weak... Abrasion noted to R [right] side of lip..."</p> <p>c. 9/4/12 - "...resident found on floor in an upright position... in dayroom bathroom... he stated "I was getting off commode trying to sit in wheelchair and lost my balance... c/o [complained of] headache... swollen red area noted on R side of face... treatment: Emergency Dept. [Department]..."</p> <p>d. 9/5/12 - "...Resident was found outside of building... laying flat on back with a swollen lip and abrasions to R side of face, knee and shoulder... treatment: Emergency Dept..."</p> <p>Review of nurses notes documented the following:</p> <p>a. 9/10/12 at 11:30 AM - "...Received back to facility from [named hospital]..."</p> <p>b. 9/10/12 at 5:30 PM - "...Resident found on floor in activities bathroom..."</p> <p>The facility was unable to provide documentation of Resident #23 being placed on a fall prevention program as care planned.</p> <p>Further review of the care plan dated 5/1/12 and reviewed 7/24/12 documented, "...Potential for Seizure Activity r/t Hx [history] of Seizure Disorder... Lab tests as ordered and notify MD of abnormal findings..."</p> <p>Review of a physician's order dated 9/2/12</p>	F 282			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 282	<p>Continued From page 131 documented, "...Dilantin level..."</p> <p>The facility was unable to provide documentation that the Dilantin level was done as ordered.</p> <p>Review of a physician's order dated 9/5/12 documented, "...Send to [named hospital] ER [emergency room] for eval [evaluation] of head due to fall on concrete..."</p> <p>Review of a hospital history and physical dated 9/5/12 documented, "...Dilantin of 31.2, normal is 10-20... admitted to the hospital with diagnosis of Dilantin toxicity... Dilantin was put on hold..."</p> <p>Review of a physician's order dated 9/10/12 documented, "...Readmit to [name of facility] post Dilantin Toxicity..."</p> <p>During an interview in the conference room on 9/13/12 at 8:00 AM, Nurse #3 was asked about the missing Dilantin results. Nurse #3 stated, "...I called the lab today and they faxed a Dilantin level that was done on 8/30/12..." Nurse #3 was asked if the physician had been notified of the 8/30/12 Dilantin level. Nurse #3 stated, "...I don't know..."</p> <p>Review of the Dilantin level completed on 8/30/12 and faxed on 9/13/12 documented a high Dilantin level of 28.8. The therapeutic reference range was 10-20.</p> <p>During an interview in the administrative office on 9/14/12 at 11:00 AM, the attending physician / medical director was asked if the facility had notified him of the 28.8 Dilantin level done 8/30/12. The medical director stated, "...No, if I</p>	F 282			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 282	<p>Continued From page 132</p> <p>had known the levels were high, I would have decreased the Dilantin..."</p> <p>During an interview in the DON's office on 9/14/12 at 1:00 PM, the DON was asked about the failure to notify the physician of the elevated Dilantin level on 8/30/12. The DON stated, "...lab has been a big issue..."</p> <p>The facility failed to follow the care plan interventions to place the resident on the fall prevention program and obtain, monitor and report abnormal dilantin levels which placed Resident #23 in IJ.</p> <p>3. Medical record review for Resident #81 documented an admission date of 6/15/07 and readmitted on 7/16/12 with diagnoses of Cerebral Vascular Accident, Hypertension, Vascular Dementia, Above the Knee Amputation, and Peripheral Vascular Disease. A physician's order dated 7/26/12 documented "monthly PT/INR [prothrombin time/normalized international ratio]." The care plan dated on 3/30/11 and updated on 8/22/12 documented, "...Potential for bleeding related to anticoagulant therapy... Obtain lab work as ordered by MD... Notify physician of abnormal lab..."</p> <p>The facility was unable to provide documentation of PT/INR lab results as ordered.</p> <p>During an interview in the conference room on 9/12/12 at 5:30 PM, the Director of Nursing (DON) stated, "Unable to find any PT/INR's since his return from the hospital [7/16/12]."</p> <p>The facility obtained a PT/INR on 9/13/12 after</p>	F 282			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 282	<p>Continued From page 133 the surveyor had asked about PT/INR results.</p> <p>On 9/14/12 at 7:40 AM, Nurse #3 brought in the results of the PT/INR that was done on 9/13/12. The PT/INR lab results drawn on 9/13/12 were abnormally high. The PT was 43.1 seconds (normal PT is 11.6-14.4 seconds) and the INR value was 4.98 (normal INR is 1.4 or less).</p> <p>During an interview in the conference room on 9/14/12 at 7:50 AM, the DON was asked what the procedure for notifying the physician was. The DON stated, "Staff are to call the physician and keep calling till [until] they get a response. If no response then they are to notify the supervisor or me. I got no call about this."</p> <p>During an interview conducted in the conference room on 9/14/12 at 8:00 AM, Nurse #4 stated, "I have talked with [named physician] it was reported late yesterday [9/13/12] and just got the lab values faxed back this morning from the lab. He [MD] ordered PT/INR every other day. I am going to draw another one today..."</p> <p>Review of a nurse's note dated 9/14/12 at 8:15 AM documented, "Called [named physician] R/E [related to] abnormal lab values. New order obtained, states he will be here this AM, PT/INR critical." There was no further documentation concerning the abnormal high lab result until a physician's order dated 9/14/12 at 8:15 AM documented, "Hold Coumadin for now, collect PT/INR every other day."</p> <p>During an interview in the administrative office on 9/14/12 at 11:00 AM, the Physician/Medical Director was asked about the abnormal high</p>	F 282			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 282	<p>Continued From page 134</p> <p>PT/INR. The attending Physician/Medical Director stated, "I got a message from my answering service about 7:00 PM yesterday [9/13/12]. I called back and no one picked up." The surveyor asked if not answering the phone happened often. The attending Physician/Medical Director stated, "Yes, that has happened before [not answering phone] but I know the nurses would contact me again if it was something serious or send patient to hospital. I saw the patient [Resident #81] this morning, ordered to hold coumadin and check PT/INR's until down to 3 then to restart Coumadin 10 mg daily... I was not aware that Coumadin 13 mg was given daily since readmission... My therapeutic INR goal is 2-3 for this patient...</p> <p>The facility failed to follow care plan interventions to obtain, monitor and report abnormal laboratory levels as ordered which placed Resident #81 in IJ.</p> <p>Further review of the care plan dated on 3/30/11 and updated on 8/22/12 documented, "...Impaired skin integrity r/t left upper chest... Administer treatment as ordered by the physician..."</p> <p>A physician's order dated 9/9/12 documented, "Xenaderm to Left Clavicle and cover with a dry dressing every day." A review of the September 2012 Treatment Administration Record (TAR) revealed no documentation of a treatment being done on the left clavicle on 9/12/12 and from 9/14/12 through 9/17/12 as ordered.</p> <p>Observations in Resident #81's room on 9/12/12 at 10:00 AM, revealed Resident #81 with a dressing noted on the left upper chest area.</p>	F 282			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 282	<p>Continued From page 135</p> <p>Observations in Resident #81's room on 9/17/12 at 10:00 AM, Nurse #1 removed the dressing that was dated 9/15/12 from the left upper chest area, revealing a wound approximately 3 inches long, 1/2 inches wide with lower 1/2 of wound bed open red and raw, with the upper part of wound was pink.</p> <p>The facility failed to follow the care plan intervention to provide treatments as ordered.</p> <p>4. Medical record review for Resident #82 documented an admission date of 1/5/11 with diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus Type I, Hypertension, Chronic Renal Disease, Bipolar Disorder, Hypothyroidism, Gout, Obesity, and Defiant Behavior. Review of the annual minimum data set (MDS) dated 6/14/12 documented in section C for cognitive patterns that Resident #82 was scored as "15" indicating the resident is cognitively intact. Review of the care plan dated 6/20/12 documented, "...POTENTIAL FOR PRESSURE ULCERS RELATED TO INCONTINENCE, IMPAIRED MOBILITY AND OBESITY... Turn and reposition resident q [every] 2 hours and prn [as needed]... PERINEAL CARE EVERY 2 HOURS... SELF CARE DEFICIT IN ADL'S [activity of daily living] R/T [related to] IMPAIRED MOBILITY... BATH DAILY..."</p> <p>During an interview Resident #82's room 401 on 9/13/12 at 4:20 PM, Resident #82 was asked if she was changed timely when wet with urine. Resident #82 stated, "Sometimes they do. Depends on who is working... They tell me I have</p>	F 282			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 282	<p>Continued From page 136</p> <p>sores on my bottom. It hurts sometimes."</p> <p>During an interview in Resident #82's room on 9/14/12 at 8:51 AM, Resident #82 stated, "My call light is broke. I had to use my cell phone to call my nurse last night [9/13/12]. I called [named Nurse #11] and I called the head nurse [Nurse #16] later. [Named Nurse #16] said there was nothing she could do about them not changing me because it was on 3 to 11 shift and they [staff] were gone. She [Nurse #16] didn't get anybody to change me. I laid here awhile and then I went to sleep. No one came back until 6 [6:00 AM] this morning. I was changed then. I was wet for a long time. I told you they didn't always change me."</p> <p>Observations in Resident #82's room on 9/14/12 at 10:24 AM, revealed Resident #82 had three stage II pressure ulcers; an open area on the left inner thigh, an open area on the right inner thigh, and an open area on the right buttock. There was no dressing on any of the wounds.</p> <p>Resident #82 was left wet with urine during the 3/11 shift on 9/13/12 until 6:00 AM, resulting in the development of two new avoidable in house acquired stage II pressure ulcers; one on the left inner thigh and one on the right buttocks.</p> <p>During an interview at the nurses' station on 1st McRee on 9/14/12 at 4:25 PM, Nurse #2 stated, "I looked at her [Resident #82] yesterday [9/13/12] and tended to the area on the right inner thigh. There was nothing else. No other areas..."</p> <p>The facility failed to provide incontinent care for a resident when staff knowingly left a resident wet with urine during the evening and night shift,</p>	F 282			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 282	<p>Continued From page 137</p> <p>which resulted in the resident developing two new avoidable in house acquired stage II pressure ulcers which placed Resident #82 in IJ.</p> <p>Review of the nursing ADL's dated August 2012, had documentation that Resident #82 received a bed bath or shower on 8/2, 8/7, 8/11, 8/12, 8/17, and 8/21. Review of the nursing ADL's dated September 2012, had no documentation Resident #82 received a bed bath or shower on 9/8 or 9/12.</p> <p>Observations in Resident #82's room on 9/10/12 at 5:13 PM, revealed Resident #82's eyes had crust around them.</p> <p>The facility failed to follow the care plan interventions to bathe daily, turn and reposition q 2 hours and prn or provide perineal care every 2 hours which placed Resident #82 in IJ when staff knowingly left the resident wet with urine during the evening and night shift and the resident developed two new avoidable in house acquired stage II pressure ulcers.</p> <p>5. Medical record review for Resident #74 documented an admission date of 2/18/10 with diagnoses of Alzheimer's Disease, Dysphagia, History of Cerebrovascular Accident, Lung Cancer with Metastasis, Hypertension, Gastro Esophageal Reflux Disease and Depression. Review of the Physician's orders dated 8/15/12 documented, "...clean Lt [left] hip area c [symbol for with] pat dry and cover c duoderm. [symbol for change] q [every] 3 days..." Review of the care plan dated 8/16/12 documented, "...Problem Impaired skin integrity... Approach Frequency... Weekly skin assessments per Charge Nurse..."</p>	F 282			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 282	<p>Continued From page 138</p> <p>Administer treatment as ordered..."</p> <p>Review of the weekly pressure ulcer records documented the following:</p> <p>a. An onset date of 5/31/12 - Stage II left hip pressure sore 1 centimeter (c) cm by (x) 1 cm less than (<) 0.1 depth.</p> <p>b. 6/7/12 - Stage II left hip pressure sore 1 cm x 1 cm <0.1 depth.</p> <p>c. 6/13/12 - Stage II left hip pressure sore 1 cm x 0.8 cm <0.1 depth.</p> <p>The facility was unable to provide documentation of weekly skin assessments from 6/13/12 until 8/20/12.</p> <p>d. 8/20/12 - Stage II left hip pressure sore 2 cm x 2 cm <0.1 depth. This pressure ulcer had deteriorated since 6/13/12.</p> <p>e. 8/27/12 - Stage II left hip pressure sore 2 cm x 1.5 cm <0.1 depth.</p> <p>Review of the Treatment Administration Record (TAR) for 9/1/12 through 9/30/12 revealed treatment for pressure ulcers was not provided as ordered on 9/1/12, 9/7/12, 9/10/12, or 9/14/12 through 9/17/12.</p> <p>Observations in Resident #74's room on 9/17/12 at 3:30 PM, Nurse #5 removed the duoderm dressing from Resident #74's left hip for assessment of the pressure ulcer. The pressure ulcer was assessed to be a Stage III with measurements of approximately 2 cm in diameter, full thickness of skin loss with reddish drainage noted on duoderm. The pressure ulcer had deteriorated to appear as a Stage III since the most recent skin assessment dated 8/27/12.</p> <p>During an interview in Resident #74's room on</p>	F 282			

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

PRINTED: 10/08/2012
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F 282	<p>Continued From page 139</p> <p>9/17/12 at 3:30 PM, Nurse #5 was asked what was the stage of the pressure sore. Nurse #5 stated, "...it's a Stage III..."</p> <p>During an interview in the MDS office on 9/18/12 at 10:43 AM, Nurse #4 was asked who is responsible to measure and stage pressure ulcers. Nurse #4 stated, "...the treatment nurse is suppose to measure the wounds weekly... The nurses on the floor are not supposed to measure or stage [pressure ulcers]..." Nurse #4 was asked who does the measurements and staging when the treatment nurse is working the floor instead of providing treatments. Nurse #4 stated, "...it has been three weeks to one month since the other treatment nurse has been here..."</p> <p>The facility failed to provide weekly pressure ulcer assessments and treatments as ordered which placed Resident #74 in IJ as evidenced by the development and deterioration of an avoidable in-house acquired pressure ulcer.</p> <p>6. Medical record review for Resident #21 documented an admission date of 1/13/99 and a readmission date of 10/12/06 with diagnoses of Late Effects of Cerebrovascular Disease, Hemiplegia affecting Dominant Side Right, Aphasia, Dementia, Depression, Gastro Esophageal Reflux Disease, Hypertension and Adult Failure to Thrive. Review of nursing re-admission assessment dated 10/12/06 documented, "...Contractures-specify Rt [right] hand..." Review of the annual MDS dated 4/11/12 and the quarterly MDS dated 7/4/12 documented in section G0400 functional limitation in ROM with upper and lower extremity on one side.</p>	F 282			

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

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NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 282	<p>Continued From page 140</p> <p>Review of the care plan dated 7/10/12 documented, "...Problem... Potential for increased contractures... Approach... Perform active and passive ROM during ADL's as indicated..."</p> <p>Review of the nursing care ADL sheets had no ROM documented on 7/4/12, 7/16/12, 7/18/12, 7/19/12, 7/20/12, 7/25/12 and 7/27/12. Review of the nursing care ADL sheets had no ROM documented on 8/2/12, 8/4/12, 8/5/12, 8/6/12, 8/9/12, 8/16/12, 8/17/12, 8/18/12, 8/19/12, 8/20/12, 8/24/12, 8/27/12, 8/28/12 and 8/31/12.</p> <p>Observations on 1st Magoffin dining room on 9/10/12 at 5:10 PM, on 9/11/12 at 7:58 AM and on 9/12/12 at 8:30 AM, revealed Resident #21 had a contracture of the right hand.</p> <p>During an interview at the nurses' station on 1st Magoffin on 9/11/12 at 8:21 AM, Nurse #6 was asked if Resident #21 had a contracture defined as a condition of fixed high resistance to passive stretch of a muscle. Nurse #6 stated, "Yes." Nurse #6 was then asked if Resident #21 received ROM services. Nurse #6 stated, "No."</p> <p>The facility failed to follow the care plan interventions for ROM exercises during ADL's.</p> <p>7. Medical record review for Resident #28 documented an admission date of 11/24/99 and a readmission date of 4/12/11 with diagnoses of Diabetes Mellitus, Gastroenteritis, Renal Insufficiency, Hypertension, Back Pain, Bipolar Disorder, Cerebrovascular Accident, Epilepsy, and Cognitive Dementia. Review of the physician orders dated 8/4/12 documented, "...BMP [Basic Metabolic Panel], HGBAIC [glycosylated</p>	F 282			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 282	<p>Continued From page 141</p> <p>hemoglobin A1C], DEPAKOTE LEVEL, EVERY... MONTHS... FEB [February], MAY, AUG [August], NOV [November]..."</p> <p>Review of the care plan dated 5/29/12 and updated 8/21/12 documented, "...Potential complications related to the use of psychotropic medication... monitor labs as ordered by physician..."</p> <p>Review of the "Consultant Pharmacist Administrative Report" dated 6/13/12 documented, "...past due labs... BMP, Lipid Panel, HgbA1c, Depakote... ordered q [every] 3 months... was due May 2012... "</p> <p>The facility was unable to provide laboratory results for the BMP, HgbA1C and Depakote level for May 2012.</p> <p>During an interview in the conference room on 9/18/12 at 8:50 AM, Nurse #4 was asked if there was a reason that lab would not have been drawn in May 2012. Nurse #4 stated, "...I can't think of any reason..."</p> <p>The facility failed to follow the care plan for monitoring labs as ordered.</p> <p>8. Medical record review for Resident #43 documented an admission date 12/22/09 with diagnoses of Vascular Dementia with Delusions, Hypertension, Diabetes Mellitus, Alcohol Abuse, Convulsions, Cerebrovascular Accident, and Left Hemiparesis. Review of the annual MDS dated 11/23/11 and the most recent quarterly MDS dated 8/1/12 documented that Resident #43 has impaired vision but does not have corrective</p>	F 282			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 282	<p>Continued From page 142</p> <p>lenses, has functional limitation in ROM on one side for the upper and lower extremities and receives psychotropic medication. Review of the care plan dated 11/29/11 and revised 8/7/12 documented, "...2. IMPAIRED VISION... 3... FOLLOW UP WITH OPHTHALMOLOGY / OPTOMETRY PHYSICIANS...</p> <p>During an interview in the activity room on 9/12/12 at 11:30 AM, Resident #43 was asked if there was any trouble reading. Resident #43 stated, "...when I read for a while my sight gets a little blurry..." Resident #43 was asked about glasses. Resident #43 stated, "...I could probably use some glasses..."</p> <p>During an interview in the Social Worker's (SW) office on 9/18/12 at 11:30 AM, the SW was asked how referrals are made for a vision consult. The SW stated, "...I get with nursing, residents and family's... then I get with [named staff] from Resident Trust to see if the resident is... eligible... or if the family is willing to pay for the glasses..." The SW was asked if Resident #43 had ever had a vision consult. The SW stated, "...I will have to check..."</p> <p>During an interview in the conference room on 9/18/12 at 1:55 PM, the SW confirmed that Resident #43 had not previously had a vision consult.</p> <p>Further review of the care plan dated 11/29/11 and revised 8/7/12 documented, "...3. SELF CARE DEFICIT IN ADL'S R/T IMPAIRED MOBILITY... ROM TO ALL EXTREMITIES AS SCHEDULED..."</p>	F 282			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 282	<p>Continued From page 143</p> <p>Review of the restorative and rehabilitation nursing assessment dated 8/9/12, documented, "...Nursing Maintenance Program... YES [checked]... Restorative Program... YES [checked]..."</p> <p>Review of the Nursing Monthly Summary dated March through July 2012 documented that Resident #43 received rehabilitation/restorative services at least 15 minutes 3 times a week. Review of Nursing Monthly Summary dated August 2012 has ROM exercises crossed off. Review of the nursing care ADL's dated March - September 2012 had ROM crossed out.</p> <p>Observations in the activity room on 9/12/12 at 10:22 AM, revealed Resident #43 participating in exercises. Resident #43 performed the exercises with both legs and right arm, but not with his left arm.</p> <p>Observations in room 109 on 9/18/12 at 7:45 AM, revealed Resident #43 seated on the side of the bed eating breakfast using right hand.</p> <p>During an interview at the nurses station on 1st Magoffin on 9/11/12 at 8:10 AM, Nurse #6 was asked if Resident #43 had a contracture defined as a condition of fixed high resistance to passive stretch of a muscle. Nurse #6 stated, "Yes... left hand." Nurse #6 was then asked if resident #43 received ROM services or had a splint device in place. Nurse #6 stated, "No."</p> <p>During an interview at the nurses station on 1st Magoffin on 9/18/12 at 8:15 AM, certified nursing assistant (CNA) #14 was asked if Resident #43 received rehabilitation or restorative services.</p>	F 282			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 282	<p>Continued From page 144</p> <p>CNA #14 stated, "...I don't see [named resident #43] "</p> <p>During an interview in the conference room on 9/18/12 at 8:50 AM, Nurse #4 was asked if Resident #43 was receiving ROM exercising. Nurse #4 stated, "...it should be documented..." Nurse #4 reviewed the medical record and stated, "...I don't see an order to discontinue ROM... that's not good if it's not documented..."</p> <p>Further review of the care plan dated 11/29/11 and revised 8/7/12 documented, "...9 POTENTIAL FOR COMPLICATIONS RELATED TO USE OF PSYCHOTROPIC MEDICATIONS... ASSESS/MONITOR ...ADVERSE SIDE EFFECTS..."</p> <p>Review of the "Summary of All Recommendations / Findings" from the Consulting pharmacist dated 6/13/12 documented, "...Please obtain an abnormal movement evaluation and place in the chart to monitor for side effects associated with antipsychotic drug therapy. This evaluation is recommended every 6 mos [months]. Last assessment 11/14 [2011].</p> <p>The facility failed to follow the care plan interventions for an eye exam, ROM exercises, and assess and monitor adverse effect for psychotropic medication.</p> <p>9. Medical record review for Resident #63 documented an admission date of 12/3/08 with diagnoses of Diabetes Mellitus, Schizophrenia, Dementia and Dyslipidemia. Review of the MDS with an assessment reference date (ARD) of</p>	F 282			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 282	<p>Continued From page 145</p> <p>10/31/11 section L was coded for D and F indicating obvious or likely cavity or broken natural teeth and mouth or facial pain, discomfort or difficulty with chewing. Review of the care plan dated 10/19/11 documented, "Problem... DENTAL PROBLEMS WITH TOOTH PAIN REPORTED... Approach... Notify MD [Medical Doctor] of any dental/mouth problem noted... REFER TO DENTIST FOR EVALUATION AND TREATMENT..."</p> <p>Observation in the dayroom on 9/10/12 at 10:30 AM, Resident #63 was noted to have two top teeth visible with brownish stains, bottom teeth chipped and broken with brownish stains noted and need of cleaning.</p> <p>Observations in the dayroom on 9/10/12 at 3:00 PM and 4:45 PM and 9/12/12 at 8:00 AM, Resident #63's teeth needed cleaning.</p> <p>During an interview in the Social Worker's (SW) office on 9/12/12 at 3:38 PM, the SW was asked about dental assistance for Resident #63. The SW stated, "I call [named dental office] and they put them [residents] on a list. If they are... eligible then the state will cover it otherwise family responsible party have to pay for it. [Named dental office] will call family and let them know cost of examination." The SW proceeded to place a call to the dental office to find out when Resident #63 was last seen by the dentist. Resident #63 was last seen by the dentist in 2007, which was prior to admission to the facility. The SW further stated, "She's [referring to Resident #63] is not... eligible so her daughter would have to pay for it and she don't like to spend money." The surveyor then asked the SW</p>	F 282			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 282	<p>Continued From page 146</p> <p>about other sources to assist with dental needs of the resident. The SW stated, "I don't have any other sources..."</p> <p>During an interview in the conference room on 9/12/12 at 4:00 PM, the Director of Nursing (DON) was asked who was responsible for dental appointments for residents. The DON stated, "Whoever did the CAA should have told nurse on unit so they could notify Social Services and she will in turn check with [named dental provider] to see if they can see her if not then we would check for our services to see who can see her."</p> <p>During an interview in the administration office on 9/12/12 at 4:20 PM, Nurse #3 was asked about a dental consult for Resident #63. Nurse #3 stated, "I put it [dental consult] on the CAA [care area assessment]. When we have the care plan meeting, I normally if SW in there will tell her then. If not in care plan meeting will call her [SW] and let her know."</p> <p>During an interview on the administration hall on 9/13/12 at 5:50 PM, the SW stated, "She doesn't have [financial resources] so her daughter will have to pay for any dental service and I know her, she doesn't like to spend any money."</p> <p>During an interview in the conference room on 9/14/12 at 1:15 PM, the DON was asked about dental appointments for residents. The DON stated, "[Named Social Worker] makes the appointment she checks to see if they have [financial resources]. If not... eligible and family can't pay then the facility has to take care of it..."</p> <p>The facility had not followed the care plan</p>	F 282			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 282	<p>Continued From page 147</p> <p>intervention to refer to the dentist for dental caries.</p> <p>10. Medical record review for Resident #84 documented an admission date of 4/11/08 with diagnoses of Senile Dementia, Esophageal Reflux, Osteoporosis, Hypertension, and Closed Fracture of Lumbar Spine. Review of the care plan dated 7/18/12 documented, "...Bath daily... hair groomed daily; nails checked daily for cleanliness and trimmed once a week... perineal (perineal) care every two hours..."</p> <p>Observations in Resident #84's room on 9/10/12 at 1:00 PM, revealed Resident #84 in bed wearing a thin hospital gown. Her nails were unkept, long and dirty, wig was unstyled and tipped forward down toward eyes.</p> <p>Observations in Resident #84's room on 9/11/12 at 8:00 AM, 12:00 PM and 2:00 PM, revealed Resident #84 wearing a thin, threadbare hospital gown. Her wig was unstyled and slipping forward down above eyes.</p> <p>Observations in Resident #84's room on 9/12/12 at 9:00 AM, 12:00 PM and 3:00 PM, revealed Resident #84's nails were long and unkept.</p> <p>Observations and interview in Resident #84's room on 9/13/12 at 9:20 AM, revealed in Resident #84 was lying in bed with wet linens. Her nails remained long and dirty her toenails were unkept. Her wig was unstyled and slipping forward down above eyes. Resident #84 stated, "...I have not had a bath today..."</p> <p>During an interview in Resident #84's room on</p>	F 282			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
(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 282	<p>Continued From page 148</p> <p>9/13/12 at 9:30 AM, Resident #84 was asked if she was wet, Resident #84 answered, "Yes." Resident #84 was asked if she had had a bath this morning. Resident #84 stated, "...I haven't had anything done for me..." Resident #84 was asked if she ever removed her wig for hair care. Resident #84 stated, "...they never brush my hair... I wish they would..."</p> <p>During an interview on 1st McRee hall on 9/13/12 at 10:00 AM, CNA #2 was asked about Resident #84's morning (9/13/12) care. CNA #2 stated, "...no I haven't bathed her yet... she was last changed on the 11-7 shift at 5:30 AM..."</p> <p>The facility failed to follow the care plan interventions for bath daily; hair groomed daily; nails checked daily for cleanliness and trimmed once a week... perineal (perineal) care every two hours..."</p> <p>11. Medical record review for Resident #104 documented an admission date of 8/2/11 with diagnoses of Schizophrenia, Dementia, Diabetes Mellitus, Seizure Disorder and Tardive Dyskinesia and a readmission date of 5/16/12 with new diagnoses of Subdural Hematoma and Percutaneous Endoscopy Gastrostomy Tube.</p> <p>Review of the care plan dated 6/4/12 documented, "...OT [Occupational Therapy]... perform therapy 5 x [times] wk [week] x 8 wks... ST [Speech Therapy] for oral dysphagia and oral therapy... provide therapy 5 x week x 60 days..." The facility was unable to provide documentation that the resident received OT and ST services.</p> <p>During an interview in the reception office on</p>	F 282			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
(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 282	<p>Continued From page 149</p> <p>9/20/12 at 8:30 AM, the receptionist was asked what the process for obtaining speech and occupational therapy was. The receptionist stated, "...the nurses notify [the Vice President] and she contacts the therapists... if there is a problem with insurance, then I make arrangements for the resident to go out for therapy..." The receptionist was asked if Resident #104 had gone out for therapy. The receptionist stated, "No."</p> <p>During an interview in the medical records office on 9/20/12 at 8:40 AM, the medical records director was asked if there were any records of OT or ST for Resident #104. The Medical Records director stated, "No."</p> <p>During an interview in the administration hallway on 9/20/12 at 8:45 AM, the Vice President was asked if there were any records of OT or ST being contacted. The Vice President stated, "No."</p> <p>During an interview in the conference room on 9/20/12 at 11:00 AM, the Vice President presented a faxed copy of an OT evaluation dated 6/4/12, which was unsigned by the physician, and a faxed copy of an OT Therapy Daily/Weekly Progress Report which covered the period of 6/4/12 to 6/10/12. The Vice President was asked about Speech Therapy notes. The Vice President shrugged. The Vice President was asked about the second week of OT notes. The Vice President stated, "...I don't know..."</p> <p>The facility failed to follow the care plan intervention for OT and ST services.</p> <p>12. Medical record review for Resident #118</p>	F 282			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 282	<p>Continued From page 150</p> <p>documented an admission date of 6/29/11 with diagnoses of Chronic Obstructive Pulmonary Disease, Right Lower Lobe Pneumonia, Anemia, Diabetes Mellitus, Hypotension, Depression, Dementia, Hypomagnesemia and Urinary Tract Infection. Review of care plan dated 9/5/12 documented, "...Administer oxygen [O2] at 2 L [liters] via BNC [binasal cannula]..."</p> <p>Observations in Resident #118's room on 9/10/12 at 10:45 AM, revealed Resident #118 lying in bed receiving O2 at 6 L/M [liters per minute] via concentrator.</p> <p>Observations in Resident #118's room on 9/14/12 at 3:00 PM, revealed Resident #118 lying in bed, receiving a breathing treatment via nebulizer and O2 at 6 L/M via concentrator.</p> <p>Observations in Resident #118's room on 9/17/12 at 9:00 AM and 11:00 AM and on 9/19/12 at 8:45 AM, revealed Resident #118 lying in bed receiving O2 at 4 L/M via concentrator.</p> <p>During an interview in Resident #118's room on 9/19/12 at 8:50 AM, Nurse #4 was asked what was the oxygen rate. Nurse #4 stated, "...It [O2] is set between 3 [L/M] and 4... it should be set on 2..."</p> <p>The facility failed to follow the care plan intervention for O2 to be administered at 2 L/M.</p> <p>13. Medical record review for Resident #124 documented an admission date of 3/23/12 with diagnoses of Atrial Fibrillation, Diabetes Mellitus, Bradycardia, Hypertension, Dementia, Agitation, Sexual Inappropriate Behavior, Alcohol Abuse,</p>	F 282			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 282	<p>Continued From page 151</p> <p>Muscle Weakness, Symbolic Dysfunction and Dysphagia Oropharyngeal Phase. Review of the care plan dated 4/5/12 and updated 6/27/12 documented, "...Alteration in visual function r/t impaired vision... will maintain optimal level of function... follow up with ophthalmology/optometry physicians..."</p> <p>Observations in Resident #124's room on 9/11/12 at 9:50 AM, revealed the resident was not wearing glasses.</p> <p>During an interview in Resident #124's room on 9/12/12 at 5:00 PM, Resident #124 was asked if he had ever had his eyes tested or if he had ever worn glasses. Resident #124 stated, "They [glasses] were stolen at the last place I was at. I probably need to be seen by an eye doctor for a new pair of glasses."</p> <p>During an interview in the MDS office on 9/14/12 at 9:00 AM, the SW was asked if Resident #124 had impaired vision at the time of admission, had no glasses then why was the needed care not addressed. The SW stated, "...I don't know. It's the resident or family member that will ask for vision consult, that's how I get notified that the resident needs glasses. Before [named school of optometry] comes out and sees them, they have to be ensured of payment. If... eligible, the state [Department of Human Services determines eligibility], will pay for the eye exam and glasses, if not, I will have to get in touch with the family..."</p> <p>During an interview in the MDS office on 9/14/12 at 10:30 AM, Nurse #3 was asked if Resident #124 had impaired vision. Nurse #3 confirmed that the resident had been assessed as having</p>	F 282			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 282	Continued From page 152 impaired vision on the comprehensive assessment at the time of admission. During an interview in business office on 9/14/12 at 10:43 AM, the Financial Services Manager (FSM) was asked if Resident #124 had been referred to her to determine... eligibility due to a request for a vision referral. The FSM stated, "...No, he has not. He is Medicaid and does receive a social security check, so that would make him... eligible..." Further review of a physician's order dated 5/10/12 and 5/30/12 documented, obtain a 3 day calorie count Review of the care plan dated 4/25/12 and updated 6/27/12 documented "...calorie count Nsg/Diet [nursing and dietician]..." Review of the nurses notes and dietary progress notes for May 2012 did not document a calorie count in progress. During an interview in the Director of Nursing (DON) office on 9/13/12 at 8:30 AM, the DON was asked if the facility had a registered dietitian. The DON stated, "...don't have one, we did have a contract with one but she hasn't been here since March..." The facility failed to follow the care plan interventions for eye exam and 3 day calorie count.	F 282			
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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	F 309			

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

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F 309	<p>Continued From page 153</p> <p>accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, pharmacy review, medical record review, observation, and interview, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable well-being by not following physician orders for obtaining laboratory (lab) tests, a swallowing study, providing treatments, administering medications, conducting a 3 day calorie count or timely notifications of lab results to the physician per the facility policy for 8 of 31 (Residents #81, 23, 28, 43, 82, 84, 104, and 124) sampled residents of the 38 residents included in the stage 2 review. The failure of the facility to obtain laboratory tests and a swallowing study, provide treatments and notify the physician of abnormal lab results as per policy placed Resident #81 immediate jeopardy (IJ). The failure of the facility to obtain lab tests as ordered resulted in IJ for Residents #23. The Administrator and Director of Nursing were informed of the IJ identified on 9/14/12 at 1:20 PM. The facility provided surveyors with a written response on 9/14/12 at 5:30 PM for process for obtaining ordered laboratory tests and for notifying the physician of critical laboratory test results. This written response was determined to be unacceptable on 9/14/12. The IJ was considered present and ongoing at the time of exit.</p> <p>The findings included:</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 309	Continued From page 154 1. Review of the facility "LAB [laboratory] POLICY" documented, "...PURPOSE: To provide adequate interventions to maintain stable health conditions... D. The LPN [Licensed Practical Nurse] will review lab results and contact the Md [Medical Doctor]. The LPN will document in the nurse's note whom, when and what information provided to MD with notation of any orders... L. The MD is to be notified of all critical lab values immediately. M. If no response from MD in (1) hour, the Nursing Supervisor is to be called. If still no response the DON [Director of Nursing] is to be notified..." 2. Medical record review for Resident #81 documented an admission date of 6/15/07 and readmitted on 7/16/12 with diagnoses of Cerebrovascular Accident, Hypertension, Vascular Dementia, Above the Knee Amputation, and Peripheral Vascular Disease. A physician's order dated 7/16/12 documented "Warfarin 3 mg [milligrams] QD [every day] and Warfarin 10 mg QHS [every night]" A physician's order dated 7/26/12 documented "monthly PT/INR [prothrombin time/normalized international ratio]." The annual Minimum Data Set (MDS) dated 3/1/12 documented a brief interview for mental status (BIMS) score of 7 (severe impairment), there were no behaviors, falls, wounds, swallowing issues, or use of anticoagulants documented. The resident was total care for activities of daily living (ADL). The quarterly MDS dated 8/16/12 documented a BIMS score of 5 (severe impairment), there were no behaviors, falls, wounds or swallowing issues documented. The resident was on daily anticoagulants.	F 309			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 309	<p>Continued From page 155</p> <p>The care plan dated dated 3/30/11 and updated on 8/22/12 documented, "...Potential for bleeding related to anticoagulant therapy... 3. Obtain lab work as ordered by MD, and ...Impaired skin integrity r/t [related to] left upper chest... 1. Administer treatment as ordered by the physician..."</p> <p>The July 2012 Medication Administration Record (MAR) documented the resident received a total of Warfarin 13 mg daily from 7/16/12 to (-) 7/31/12. The August 2012 MAR documented the resident received a total of Warfarin 13 mg daily from 8/1/12-8/31/12. The September 2012 MAR documented the resident received Warfarin 13 mg daily 9/1/12-9/13/12.</p> <p>The facility was unable to provide documentation of PT/INR lab results as ordered.</p> <p>During an interview in the conference room on 9/12/12 at 5:30 PM, the Director of Nursing (DON) stated, "Unable to find any PT/INR's since his return from the hospital [7/16/12]."</p> <p>The facility obtained a PT/INR on 9/13/12 after the surveyor had asked about PT/INR results.</p> <p>On 9/14/12 at 7:40 AM, Nurse #3 brought in the results of the PT/INR that was done on 9/13/12. The PT/INR lab results drawn on 9/13/12 were abnormally high. The PT was 43.1 seconds (normal PT is 11.6-14.4 seconds) and the INR value was 4.98 (normal INR is 1.4 or less).</p> <p>During an interview in the conference room on 9/14/12 at 7:50 AM, the DON was asked what the</p>	F 309			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 309	<p>Continued From page 156</p> <p>procedure for notifying the physician was. The DON stated, "Staff are to call the physician and keep calling till [until] they get a response. If no response then they are to notify the supervisor or me. I got no call about this."</p> <p>During an interview conducted in the conference room on 9/14/12 at 8:00 AM, Nurse #4 stated, "I have talked with [named physician] it was reported late yesterday [9/13/12] and just got the lab values faxed back this morning from the lab. He [MD] ordered PT/INR every other day. I am going to draw another one today..."</p> <p>Review of a nurse's note dated 9/14/12 at 8:15 AM documented, "Called [named physician] R/E [related to] abnormal lab values. New order obtained, states he will be here this AM, PT/INR critical." There was no further documentation concerning the abnormal high lab result until a physician's order dated 9/14/12 at 8:15 AM documented, "Hold Coumadin for now, collect PT/INR every other day."</p> <p>During an interview in the administrative office on 9/14/12 at 11:00 AM, the Physician/Medical Director was asked about the abnormal high PT/INR. The attending Physician/Medical Director stated, "I got a message from my answering service about 7:00 PM yesterday [9/13/12]. I called back and no one picked up." The surveyor asked if not answering the phone happened often. The attending Physician/Medical Director stated, "Yes, that has happened before [not answering phone] but I know the nurses would contact me again if it was something serious or send patient to hospital. I saw the patient [Resident #81] this morning, ordered to hold</p>	F 309			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 309	<p>Continued From page 157</p> <p>coumadin and check PT/INR's until down to 3 then to restart Coumadin 10 mg daily... I was not aware that Coumadin 13 mg was given daily since readmission... My therapeutic INR goal is 2-3 for this patient... I don't remember who told me about his wound. I did look at it, it was a fresh wound, very unusual shape and area..."</p> <p>Review of nurse's note dated 9/14/12 at 10:30 AM, documented, "Attempted to drawn a PT/INR. Resident refused stating "no" and jerking his arm back, pt. [patient] is scheduled for MBS [modified barium swallow]."</p> <p>During an interview at the 1st McRee nursing station on 9/15/12 at 8:05 AM, Nurse #4 stated, "No I did not document that I notified [named physician] that [named Resident #81] refused to let me draw the lab."</p> <p>Further review of a physician's order dated 8/17/12 documented, "MBS and speech eval [evaluation] due to coughing while eating." There was no documentation of the MBS being done until 9/14/12 with a MBS Study that documented the following recommendations: 1 NPO [nothing by mouth], 2. Dysphagia tx [treatment] for focus on laryngeal elevation and closure... 3. Repeat MBS in 2-3 weeks."</p> <p>Observations in Resident #81's room on 9/12/12 at 10:00 AM, revealed Resident #81 with a dressing noted on the left upper chest area.</p> <p>Observations in Resident #81's room on 9/17/12 at 10:00 AM, Nurse #1 removed the dressing that was dated 9/15/12 from the left upper chest area, revealing a wound approximately 3 inches long,</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 309	<p>Continued From page 158</p> <p>1/2 inches wide with lower 1/2 of wound bed open red and raw, with the upper part of wound was pink. The dressing that was removed had brown drainage present.</p> <p>Observations in Resident #81's room on 9/18/12 at 7:45 AM, Resident #81 coughing while eating a pureed diet.</p> <p>During an interview in Resident #81's room on 9/18/12 at 7:45 AM, certified nursing assistant (CNA) #3 stated, "He [Resident #81] feeds himself. I come back and check on him and help if he needs it. I have noticed since he came back from the hospital [7/16/12] that he is coughing more with eating. I did tell the charge nurse about it."</p> <p>During an interview in the conference room on 9/18/12 at 6:00 PM, the Physician was asked if he knew the swallowing study was not obtained until 9/18/12. The Physician stated, "No I was not aware that they did not get the swallow study until today. He [Resident #81] is now NPO, currently has IV's [intravenous fluids] going for hydration, family is being contacted for a possible PEG [Percutaneous Endoscopy Gastrostomy tube], if they refuse the PEG then hospice will be contacted. I am not sure how speech therapy works here, will check, if it works we can reverse the PEG."</p> <p>A physician's order dated 9/9/12 documented, "Xenaderm to Left Clavicle and cover with a dry dressing every day." A review of the September 2012 Treatment Administration Record (TAR) revealed no documentation of a treatment being done on the left clavicle on 9/12/12 and from</p>	F 309			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 309	<p>Continued From page 159 9/14/12 through 9/17/12 as ordered.</p> <p>The facility failed to obtain lab work and a MBS as ordered; keep the physician notified of the resident status; timely notify the physician of status and provide treatments as ordered. The facility failed to notify the physician that the monthly PT/INR labs were not obtained as ordered and once obtained failed to timely notify the physician of the abnormal high which resulted Resident #81 in IJ.</p> <p>3. Medical record review for Resident #23 documented an admission date of 1/29/99 with diagnoses of Subarachnoid Hemorrhage, Diabetes, Hemiplegia, Dementia, Hypertension and Seizure Disorder and a readmission date of 9/10/12 with a new diagnosis of Dilantin Toxicity. Review of a physician's order dated 9/2/12 documented, "...Dilantin level, CBC [Complete Blood Count], CMP [Complete Metabolic Profile], Urine C&S [Culture and Sensitivity]..."</p> <p>The facility was unable to provide documentation that the lab results for Dilantin level, CBC, CMP, Urine C&S had been done as ordered.</p> <p>Review of a physician's order dated 9/5/12 documented, "...Send to [named hospital] ER [emergency room] for eval [evaluation] of head due to fall on concrete..."</p> <p>Review of a hospital history and physical dated 9/5/12 documented, "...Dilantin of 31.2, normal is 10-20... admitted to the hospital with diagnosis of Dilantin toxicity... Dilantin was put on hold..."</p> <p>Review of a physician's order dated 9/10/12</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 309	<p>Continued From page 160 documented, "...Readmit to [name of facility] post Dilantin Toxicity..."</p> <p>During an interview in the conference room on 9/13/12 at 8:00 AM, Nurse #3 was asked about the missing Dilantin results. Nurse #3 stated, "...I called the lab today and they faxed a Dilantin level that was done on 8/30/12..." Nurse #3 was asked if the physician had been notified of the 8/30/12 Dilantin level. Nurse #3 stated, "...I don't know..."</p> <p>Review of the Dilantin level completed on 8/30/12 and faxed on 9/13/12 documented a high Dilantin level of 28.8. The therapeutic reference range was 10-20.</p> <p>During an interview in the administrative office on 9/14/12 at 11:00 AM, the attending physician / medical director was asked if the facility had notified him of the 28.8 Dilantin level. The medical director stated, "...No, if I had known the levels were high, I would have decreased the Dilantin..."</p> <p>During an interview in the DON's office on 9/14/12 at 1:00 PM, the DON was asked about the failure to notify the physician of the elevated Dilantin level. The DON stated, "...lab has been a big issue..."</p> <p>The facility failed to obtain, monitor and report Dilantin levels as ordered which placed Resident #23 in IJ.</p> <p>4. Medical record review for Resident #28 documented an admission date of 11/24/99 and a readmission date of 4/12/11 with diagnoses of Gastroentroenteritis, Renal Insufficiency, Back</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 309	<p>Continued From page 161</p> <p>Pain, Diabetes Mellitus, Hypertension, Cerebrovascular Accident, Epilepsy, Bipolar Disorder, and Cognitive Dementia. Review of the physician orders dated 8/4/12 documented, obtain "...BMP [Basic Metabolic Panel], HGBAIC [glycosylated Hemoglobin A1c], DEPAKOTE LEVEL, EVERY... MONTHS... FEB [February], MAY, AUG [August], NOV [November]..."</p> <p>Review of the "Consultant Pharmacist Administrative Report" dated 6/13/12 documented, "...past due labs... BMP, Lipid Panel, HgbA1c, Depakote... ordered q [every] 3 months... was due May 2012..."</p> <p>The facility was unable to provide documentation that the BMP, HgbA1C and Depakote level were obtained as ordered.</p> <p>During an interview in the conference room on 9/18/12 at 8:50 AM, Nurse #4 was asked if there was a reason the labs would not have been drawn in May 2012. Nurse #4 stated, "...I can't think of any reason..."</p> <p>5. Medical record review for Resident #43 documented an admission date 12/22/09 with diagnoses of Vascular Dementia with Delusions, Hypertension, Diabetes Mellitus, Alcohol Abuse, Convulsions, Cerebrovascular Accident, and Left Hemiparesis. Review of the physician's orders dated 6/6/12 documented, "...DILANTIN [Phenytoin] LEVEL EVERY 3 MONTHS (MAY/AUG/NOV/FEB)..."</p> <p>Review of the "Consultant Pharmacist Administrative Report" dated 6/13/12 documented, "...following lab(s) past due..."</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 309	<p>Continued From page 162</p> <p>Phenytoin... ordered every 3 months... was due May 2012... "</p> <p>The facility was unable to provide documentation that the Dilantin level was done as ordered.</p> <p>During an interview in the conference room on 9/18/12 at 8:50 AM, Nurse #4 was asked if there was a reason that the lab would not have been drawn in May 2012. Nurse #4 stated, "...I can't think of any reason..."</p> <p>6. Medical record review for Resident #82 documented an admission date of 1/5/11 with diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus Type I, Hypertension, Chronic Renal Disease, Bipolar Disorder, Hypothyroidism, Gout, Obesity, and Defiant Behavior. Review of the August 2012 physician's order documented the following, "...ALLOPURINOL 100 MG TABLET TAKE 1 TABLET BY MOUTH DAILY... ASPRIN EC [enteric coated] 325 MG TABLET TAKE 1 TABLET BY MOUTH DAILY... ATENOLOL 25 MG TABLET TAKE 1 TABLET BY MOUTH DAILY... LASIX 29 MG qd [daily]... COLACE 100 MG... TAKE 1 CAPSULE BY MOUTH DAILY... DILTIAZEM 240 MG... TAKE 1 CAPSULE BY MOUTH... GLUCOPHAGE 500 MG TABLET... TAKE 1 TABLET BY MOUTH DAILY... RISPERDAL 2 MG TABLET... TAKE 1 TABLET BY MOUTH EVERY MORNING... DEPAKOTE 500 MG TABLET... PRILOSEC 20 MG CAPSULE... TAKE 1 CAPSULE BY MOUTH 2 TIMES DAILY BEFORE MEALS... ARTIFICIAL TEARS DROPS INSTILL 1 DROP INTO EACH EYE 4 TIMES DAILY... KLONOPIN 1 MG TABLET... TAKE 1 TABLET BY MOUTH AT</p>	F 309			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 309	<p>Continued From page 163</p> <p>BEDTIME... RISPERDAL 4 MG TABLET...TAKE 1 TABLET BY MOUTH AT BEDTIME...MULTIVITAMIN TABLET TAKE 1 TABLET BY MOUTH DAILY..." Review of a physician's order dated 9/13/12 documented, "...Keflex 500mg tid [three times daily] x [times] 7 days..."</p> <p>Review of the medication administration record (MAR) dated 9/1/12 through 9/30/12 for Resident #82 revealed the resident did not receive the following medications as ordered on the dates listed:</p> <ul style="list-style-type: none"> a. Artificial Tears 1 drop into each eye at 5 PM and 9 PM on 9/11/12 through 9/15/12 or on 9/17/12. b. Klonopin 1 milligram (mg) at hour of sleep (hs) from 9/12/12 through 9/14/12 and on 9/17/12. c. Risperdal 4 mg at hs from 9/12/12 through 9/14/12. d. Risperdal 2 mg at 9 AM on 9/3/12 or 9/14/12. e. Prilosec 20 mg at 7:30 AM on 9/4/12 or at 5 PM from 9/12/12 through 9/14/12. f. Allopurinol 100 mg at 9 AM on 9/3/12. g. Aspirin 325 mg at 9 AM on 9/3/12. h. Atenolol 25 mg at 9 AM on 9/3/12. i. Colace 100 mg at 9 AM on 9/3/12. j. Diltiazem 240 mg at 9 AM on 9/3/12. k. Glucophage 500 mg at 9 AM on 9/3/12. l. Lasix 20 mg at 9 AM on 9/3/12. m. Depakote 500 mg at 9 AM on 9/3/12 or at 5 PM from 9/12/12 through 9/14/12. n. Multivitamin at 9 AM on 9/3/12. o. Keflex 500mg at 5 PM on 9/17 or 9 AM on 9/18. <p>During an interview at the 1st McRee nurses' station on 9/19/12 at 3:30 PM, Nurse #4 was</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 309	<p>Continued From page 164</p> <p>asked if medications were administered to Resident #82 as ordered. Nurse #4 reviewed the MAR for September 2012 and stated, "No, it's [medication administration] not documented."</p> <p>7. Medical record review for Resident #84 documented an admission date of 4/11/08 with diagnoses of Senile Dementia, Esophageal Reflux, Osteoporosis, Hypertension, and Closed Fracture of Lumbar Spine. Review of a physician's order dated 8/19/12 documented, "...GGT [Gamma glutamyl transferase] lab test..."</p> <p>Review of a history and physical dated 8/19/12 documented, "...Impression: R/O [rule out] liver disease... Plan: GGT to rule out liver disease as source of ^ [increased] alk [alkaline] phos [phosphatase]..."</p> <p>The facility was unable to provide lab results for a GGT as ordered in August 2012.</p> <p>During an interview in the medical records office on 9/19/12 at 3:30 PM, medical records director was asked about the GGT results. The medical records director stated, "...we cannot locate them [GGT lab results]..."</p> <p>8. Medical record review for Resident #104 documented an admission date of 8/2/11 with diagnoses of Schizophrenia, Dementia, Diabetes Mellitus, Tardive Dyskinesia and Seizure Disorder. A readmission date of 5/16/12 with new diagnoses of Subdural Hematoma and Percutaneous Endoscopy Gastrostomy Tube. Review of a physician's order dated 10/8/11 documented, "...CBC c [with] DIFFERENTIAL q [every] 2 WEEKS..."</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 309	Continued From page 165 Review of a physician's order dated 11/4/11 documented, "...Pt [patient] should be having a WBC [white blood count] with differential every 2 weeks. Has not been being done. WBC with diff [differential] q 2 weeks..." Review of a physician's order dated 11/15/11 documented, "...BE SURE AND DO A WBC c DIFFERENTIAL ON 11-17-11..." Review of a physician's order dated 11/30/11 documented, "...WE NEED CBC c DIFFERENTIAL REPORT FROM 11-17-11 ON THE CHART. CONTINUE CBC c DIFFERENTIAL EVERY 2 WEEKS. PT. [patient] IS ON CLOZARIL AND WE NEED TO CHECK FOR NEUTROPENIA PERIODICALLY. THAT'S WHY WE DO THE CBC's AND DIFFERENTIALS TO TRY TO AVOID INFECTIONS..." The facility was unable to provide documentation of lab results for the CBC and WBC with differentials as ordered. During an interview in the DON's office on 9/14/12 at 12:20 PM, the DON was asked about the lab reports which were unavailable. The DON stated, "...lab has been a big issue..." 9. Medical record review for Resident #124 documented an admission date of 3/23/12 with diagnoses of Atrial Fibrillation, Diabetic Mellitus, Bradycardia, Hypertension, Dementia, Agitation, Sexual Inappropriate Behavior, Alcohol Abuse, Muscle Weakness, Symbolic Dysfunction and Dysphagia Oropharyngeal Phase. Review of a physician's orders dated 5/10/12 documented,	F 309			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 309	Continued From page 166 "Calorie Count x [times] 3 days..." Review of a physician's order dated 5/30/12 documented, "3 day calorie count to start today..."	F 309			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 medical record review, observation, and interview, it was determined the facility failed to carry out the necessary care and services needed to maintain grooming and good hygiene for 5 of 34 (Residents #6, 14, 82, 84, and 118) sampled residents reviewed of the 38 residents in the included in the stage 2 review. The findings included: 1. Medical record review for Resident #6 documented an admission on 5/15/2000 with diagnoses of Paralysis Agitans, Hypertension, Osteoarthritis, Osteoporosis, Percutaneous Endoscopy Gastrostomy (PEG), Adult Failure to Thrive, History of Cerebrovascular Accident, Depressive Disorder, Neurogenic Bladder, and Osteopenia. Observations in Resident #6's room on 9/10/12 at	F 312			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 312	<p>Continued From page 167</p> <p>11:15 AM, revealed Resident #6's eyes were matted.</p> <p>Observations in Resident #6's room on 9/10/12 at 5:10 PM, revealed Resident #6's eyes were matted and lips were dry.</p> <p>During a phone interview in the conference room on 9/12/12 at 8:50 AM, the family member of Resident #6 stated, "She [Resident #6] was dirty, not cared for...was soiled... I could not find a nurse at first, she [nurse] eventually came around but did not know anything about the patient... How can she effectively care for patient's if she doesn't know their history?"</p> <p>2. Medical record review for Resident #14 documented an admission date of 6/16/09 with diagnoses of Diabetes Mellitus, Hypertension, Status Post Cerebrovascular Accident, Schizoaffective Disorder - Bipolar Type, Obesity, Bipolar Disorder and Constipation. Review of the annual Minimum Data Set (MDS) dated 12/8/11 documented a Brief Interview for Mental Status (BIMS) score of 15. The quarterly MDS dated 8/15/12 documented a BIMS score of 11. Resident #14's BIMS scores indicates she is cognitively aware. Review of the annual MDS assessment dated 12/8/11 and quarterly MDS dated 8/15/12 documented, Resident #14 totally dependent on staff for bathing, toileting and always incontinent.</p> <p>Review of the nursing care activities of daily living (ADL) record dated August 2012 and September 2012 had no showers documented for on any shift. Review of the bath days section documented Resident #14 was to have showers</p>	F 312			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 312	<p>Continued From page 168 on Tuesday, Thursday, and Saturday.</p> <p>Review of the care plan dated 8/22/12 documented, "Problem ALTERATION IN ELIMINATION R/T [related to] BOWEL AND BLADDER INCONTINENCE... Approach... CHECK RESIDENT AT LEAST Q [every] 2 HOUR AND GIVE PERI [perineal] CARE AFTER INCONTINENT EPISODES FOLLOWED BY MOISTURE BARRIER... Goal RESIDENT WILL BE CLEAN, DRY FREE OF BODY ODOR AND SKIN BREAKDOWN..."</p> <p>Observations in Resident #14's room on 9/12/12 at 8:20 AM, 1:20 PM, and 4:00 PM, on 9/13/12 at 8:18 AM, and on 9/14/12 at 9:00 AM, revealed a urine odor in the room.</p> <p>During an interview in Resident #14's room on 9/10/12 at 5:30 PM, Resident #14 was asked do you choose how many times a week you take a bath or shower. Resident #14 stated, "...no, two showers out of a month and a bed bath in between..."</p> <p>During an interview at the 1st McRee nurses' station, on 9/14/12 at 8:40 AM, Nurse #7 was asked when are residents showered. Nurse #7 stated, "...showered according to their schedule..." Nurse #7 was shown Resident #14's "Bath Days" documentation and was asked why no showers were documented. Nurse #7 stated, "...sometimes she refuses showers.. just wants a bed bath... depends on her mood that day..." Nurse #7 was asked how often residents were checked and changed. Nurse #7 stated, "...on shift every 2 hours... doesn't wear briefs, just pads..."</p>	F 312			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 312	Continued From page 169 3. Medical record review for Resident #82 documented an admission date of 1/5/11 with diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus Type I, Hypertension, Chronic Renal Disease, Bipolar Disorder, Hypothyroidism, Gout, Obesity, and Defiant Behavior. Review of the quarterly MDS dated 12/30/11 and the annual MDS dated 6/14/12 cognitive patterns was coded 15 indicating she was independent in decision making, and Section G functional status coded Resident #82 as required physical help in part of bathing and assistance of one person. Review of the nursing care activities of daily living (ADL's) dated August 2012, had no documentation that Resident #82 received a bed bath or shower on 8/2, 8/7, 8/11, 8/12, 8/17, and 8/21/12. There was no documentation on the September 2012 ADL sheet that Resident #82 received a bed bath or shower on 9/8 or 9/12/12. Review of the care plan dated 6/20/12 documented, "...SELF CARE DEFICIT IN ADL'S R/T [related to] IMPAIRED MOBILITY... BATH DAILY..." During an interview at the 1st McRee nurses' station on 9/12/12 at 8:55 AM, certified nursing assistant (CNA #2) was asked if Resident #82 received a bed bath daily. CNA #2 looked at the ADL sheet and stated, "There should be something in those blanks for those days... The aide on those days didn't usually work this floor, so she may not have given it. Can't tell." During an interview in the activity room on	F 312			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 312	<p>Continued From page 170</p> <p>9/12/12 at 10:10 AM, Resident #82 was asked if she received a bed bath daily. Resident #82 stated, "I get spots washed, but not a bed bath every day. No, they don't do a whole bed bath every day like they are supposed to."</p> <p>4. Medical record review for Resident #84 documented an admission date of 4/11/08 with diagnoses of Senile Dementia, Esophageal Reflux, Osteoporosis, Hypertension, and Closed Fracture of Lumbar Spine. Review of the care plan dated 7/18/12 documented, "...Bath daily; oral care daily and prn [as needed]; hair groomed daily; nails checked daily for cleanliness and trimmed once a week... provide clean, seasonal clothing daily and prn... perineal [perineal] care every two hours..."</p> <p>Observations in Resident #84's room on 9/10/12 at 1:00 PM, revealed Resident #84 in bed wearing a thin, threadbare hospital gown. The resident's nails were unkept, long and dirty. Resident #84 was wearing an unstyled wig that was tipped forward down toward her eyes. There was visible facial hair on the resident's chin.</p> <p>Observations in Resident #84's room on 9/11/12 at 8:00 AM, 12:00 PM and 2:00 PM, revealed Resident #84 wearing a thin, threadbare hospital gown. Her wig was unstyled and slipping forward down above eyes.</p> <p>Observations in Resident #84's room on 9/12/12 at 9:00 AM, 12:00 PM and 3:00 PM, revealed Resident #84's nails were long and unkept; linens were thin and discolored.</p> <p>Observations and interview in Resident #84's</p>	F 312			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 312	<p>Continued From page 171</p> <p>room on 9/13/12 at 9:20 AM, revealed in Resident #84 was lying in bed with wet linens. Her nails remained long and dirty her toenails were unkept. Her wig was unstyled and slipping forward down above eyes. Resident #84 stated, "...I have not had a bath today..."</p> <p>During an interview in Resident #84's room on 9/13/12 at 9:30 AM, Resident #84 was asked if she was wet, Resident #84 answered, "Yes." Resident #84 was asked if she had had a bath this morning. Resident #84 stated, "...I haven't had anything done for me..." Resident #84 was asked if she ever removed her wig for hair care. Resident #84 stated, "...they never brush my hair... I wish they would..."</p> <p>During an interview on 1st McRee hall on 9/13/12 at 10:00 AM, CNA #2 was asked about Resident #84's morning (9/13/12) care. CNA #2 stated, "...no I haven't bathed her yet... she was last changed on the 11-7 shift at 5:30 AM..."</p> <p>5. Medical record review for Resident #118 documented an admission date of 6/29/11 with diagnoses of Chronic Obstructive Pulmonary Disease, Right Lower Lobe Pneumonia, Anemia, Diabetes Mellitus, Hypotension, Depression, Dementia, Hypomagnesemia, and Urinary Tract Infection. Review of the MDS dated 3/27/12 documented a BIMS score of 10, always continent of bladder and bowel, requires assist of 1 person for bath and hygiene. Review of the MDS dated 8/30/12 documented a BIMS score of 8, frequently incontinent of bladder, always incontinent of bowel, requires assist of 1 person for bath and hygiene. Review of the care plan dated 9/5/12 documented, "...Self-care Deficit:</p>	F 312			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 312	Continued From page 172 Resident will be neat, appropriately dressed, free of body odor... approach: daily bath... Alteration in elimination r/t [related to] bowel and bladder incontinence... check resident at least q [every] 2 hour and give pericare after incontinent episodes followed by moisture barrier..." Observations in Resident #118's room on 9/10/12 at 10:45 AM, revealed Resident #118 lying in bed with a strong urine odor at the bedside and in the closet. Observations in Resident #118's room on 9/14/12 at 3:00 PM, revealed Resident #118 lying in bed with a strong urine odor at the bedside. Observations in Resident #118's room on 9/17/12 at 9:00 AM and 11:00 AM and on 9/19/12 at 8:45 AM, revealed Resident #118 lying in bed with a strong odor of urine throughout the room. During an interview in the hallway on 1st McRee on 9/19/12 at 9:00 AM, CNA #2 was asked about Resident #118's morning care. CNA #2 stated, "...haven't gotten to him yet..."	F 312			
F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.	F 313			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 313	Continued From page 173 This REQUIREMENT is not met as evidenced by: Based on review of the Social Worker's (SW) job description, medical record review, observation, and interview, it was determined the facility failed to ensure that residents received proper treatment and assistive devices to maintain vision ability for 3 of 27 (Residents #43, 60 and 124) sampled residents of the 38 residents included in the stage 2 review. The findings included: 1. Review of the facility's "Social Worker" (SW) job description documented, "Provides...targeted intervention for social, emotional and environmental issues that impact client/family ability to optimally benefit from care. Actively collaborates with team to meet client care, outcome management and system improvement goals... 4. Maintains timely documentation. 4a. Consistently meets facility and regularly mandated documentation standards..." 2. Medical record review for Resident #43 documented an admission date of 12/22/09 with diagnoses of Vascular Dementia with Delusions, Diabetes Mellitus, Alcohol Abuse, Hypertension, Convulsions, Cerebrovascular Accident, and Left Hemiparesis. Review of the annual minimum data set (MDS) dated 11/23/11 and the most recent quarterly MDS dated 8/1/12 documented that Resident #43 had impaired vision but did not have corrective lenses. Review of the care plan dated 11/29/11 and revised 8/7/12 documented, "...IMPAIRED VISION... 3... FOLLOW UP WITH OPHTHALMOLOGY / OPTOMETRY	F 313			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 313	<p>Continued From page 174</p> <p>PHYSICIANS..." The facility was unable to provide documentation of a consult for vision services.</p> <p>Observations in the activity room on 9/12/12 at 11:28 AM, revealed Resident #43 was not wearing glasses.</p> <p>During an interview in the activity room on 9/12/12 at 11:30 AM, the surveyor asked Resident #43 if he had any trouble reading. Resident #43 stated, "...when I read for a while my sight gets a little blurry..." Resident #43 was asked about glasses. Resident #43 stated, "...I could probably use some glasses..."</p> <p>During an interview in the SW's office on 9/18/12 at 11:30 AM, the SW was asked how referrals are made for a vision consult. The SW stated, "...I get with nursing, residents and family's... then I get with [named the financial service manager] from Resident Trust to see if the resident is... eligible... or if the family is willing to pay for the glasses..." The SW was asked if Resident #43 had ever had a vision consult. The SW stated, "...I will have to check..."</p> <p>During an interview in the conference room on 9/18/12 at 1:55 PM, the SW confirmed that Resident #43 had not previously had a vision consult.</p> <p>3. Medical record review for Resident #60 documented an admission date of 3/5/10 with diagnoses of Right and Left Heel Wounds, Diabetes Mellitus, Gastro Esophageal Reflux Disease, Multiple Sclerosis, Hypertension and Hypothyroidism. Review of the MDS with an</p>	F 313			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 313	<p>Continued From page 175</p> <p>assessment reference date (ARD) of 7/18/12 section B for vision was coded zero indicating no corrective lens. Review of the care area assessment (CAA) with an ARD of 7/18/12 documented, "...visual function summary notes Resident triggered D/T [due/to] impaired vision..."</p> <p>An eye exam from an eye clinic dated 9/4/11 had a written prescription for glasses. An authorization form for a college of optometry documenting authorization for eyeglasses signed by Resident #60's Responsible Party (RP) and dated 3/8/10. Resident #60's medical record documented "...Glasses Dispensing Form..." dated 1/11/12.</p> <p>Review of the care plan dated 2/9/12 documented, "...IMPAIRED VISION... Approach... 3 FOLLOW UP WITH OPHTHALMOLOGY / OPTOMETRY PHYSICIANS..."</p> <p>Review of the social service progress (SSP) notes dated 9/2/10, 12/2/10 documented, "...Resident is seen as needed by...eye care..."</p> <p>Observations in Resident #60's room on 9/12/12 at 3:30 PM, revealed Resident #60 with glasses on.</p> <p>During an interview in Resident #60's room on 9/12/12 at 6:15 PM, Resident #60 was asked how long he had glasses. Resident #60 stated, "...6 or 7 months... my brother bought them for me..."</p> <p>During an interview in the conference room on 9/14/12 at 12:30 PM, the SW was asked for clarification of Resident #60's obtaining glasses. The SW validated Resident #60 came to her and</p>	F 313			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 313	<p>Continued From page 176</p> <p>told her he needed glasses. The SW stated this was sometime in October 2011.</p> <p>During an interview in the conference room on 9/14/12 at 12:30 PM, the SW was asked if she had documented that this resident needed glasses or was there notification of RP or any attempts to help this resident get the items he needed. The SW stated, "No."</p> <p>4. Medical record review for Resident #124 documented an admission date of 3/23/12 with diagnoses of Atrial Fibrillation, Diabetic Mellitus, Dementia, Agitation, Bradycardia, Hypertension, Sexual Inappropriate Behavior, Alcohol Abuse, Muscle Weakness, Symbolic Dysfunction and Dysphagia Oropharyngeal Phase. Review of the MDS with an assessment reference date (ARD) of 3/29/12, 4/2/12, 4/10/12 and 6/21/12 documented in Section B1000 Ability to see in adequate light, the resident is assessed as having, "...Impaired - sees large print, but not regular print in newspapers / books..." Review of the CAA dated 3/29/12 documented, "...Summary notes... Vision ...Impaired... Resident triggered because he has impaired vision. His ability to see only in adequate light. Resident stated during interview that he does not have his glasses that were missing before admission to the facility. We will care plan to anticipate the resident's needs. We will also notify the ophthalmology department for new glasses, if possible." Review of the care plan dated 4/5/12 and updated 6/27/12 documented, "...Alteration in visual function r/t [related to] impaired vision... will maintain optimal level of function... follow up with ophthalmology/optometry physicians..." The facility was unable to provide documentation of a</p>	F 313			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 313	<p>Continued From page 177 referral to ophthalmology/optometry.</p> <p>Observations in Resident #124's room on 9/11/12 at 9:50 AM, revealed Resident #124 was not wearing glasses.</p> <p>During an interview in Resident #124's room on 9/12/12 at 5:00 PM, Resident #124 was asked if he had ever had his eyes tested or if he had ever worn glasses. Resident #124 stated, "They [glasses] were stolen at the last place he was at and that he probably needed to be seen by an eye doctor for a new pair of glasses."</p> <p>During an interview in the MDS office on 9/14/12 at 9:00 AM, the SW was asked if Resident #124 had impaired vision at the time of admission, had no glasses then why was the needed care not addressed. The SW stated, "...I don't know. It's the resident or family member that will ask for vision consult, that's how I get notified that the resident needs glasses. Before [named school of optometry] comes out and sees them, they have to be ensured of payment. If... eligible, the state [Department of Human Services determines eligibility], will pay for the eye exam and glasses, if not, I will have to get in touch with the family..."</p> <p>During an interview in the MDS office on 9/14/12 at 10:30 AM, Nurse #3 was asked if Resident #124 had impaired vision. Nurse #3 confirmed that the resident had been assessed as having impaired vision on the comprehensive assessment at the time of admission.</p> <p>During an interview in business office on 9/14/12 at 10:43 AM, the Financial Services Manager (FSM) was asked if Resident #124 had been</p>	F 313			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 313	Continued From page 178 referred to her to determine eligibility... due to a request for a vision referral. The FSM stated, "...No, he has not. He is Medicaid and does receive a social security check, so that would make him... eligible..."	F 313			
F 314 SS=J	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. 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 identify, assess, accurately assess, provide treatments and/or use preventive measures to prevent the development of avoidable pressure ulcers for 4 of 4 (Residents #54, 60, 74 and 82) sampled residents at risk of developing pressure ulcers of the 38 residents included in the stage 2 review. Failure of the facility to identify, assess, accurately assess and/or provide care and treatments resulted in an immediate jeopardy (IJ) when Resident #54 and #82 developed avoidable in-house acquired pressure ulcers and Resident #54 and 74's pressure ulcers deteriorated. The Administrator and the Director of Nursing were informed of this IJ on 9/14/12 at 4:55 PM. This IJ was considered	F 314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 314	<p>Continued From page 179 present and ongoing at the time of exit.</p> <p>The findings included:</p> <p>1. Review of the facility's "Identifying Residents at Risk for Pressure Ulcers" policy documented, "...Re-assess all patients on re-admission to the facility and bi-monthly on skilled unit and monthly on ICF [Intermediate Care facility] residents utilizing the Resident Skin Evaluation... Include skin assessment in daily charting on SNF [Skilled Nursing Facility] residents and in weekly charting on ICF residents... Wound Assessments and Documentation: Accurate assessment and documentation of wounds and wound status is important in management of wounds. The following factors should be documented on a weekly basis as directed... Weekly documentation should be done on the Treatment Flow Record. In addition a skin evaluation will be noted in the monthly and bi-monthly Skin Assessments completed by the staff nurse... Wound Classification... Stage I - Areas of skin redness (without a break in the skin) that does not disappear within 30 minutes after pressure is relieved. Stage II - Partial thickness loss of skin layers, may present clinically as an abrasion, blister, or shallow crater. Stage III - Full thickness of skin lost, exposing subcutaneous tissues... Appropriate Intervention should be implemented for all wounds. Pressure reduction mattress... Turn/Reposition every 2 hours... Keep clean, dry and well lubricated..."</p> <p>Review of the facility's "SKIN CARE AND EARLY TREATMENT" policy documented, "...Skin to be inspected every shift by direct caregivers paying close attention to bony prominence. Observe and</p>	F 314			

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F 314	<p>Continued From page 180</p> <p>report any unusual skin conditions to the charge nurse on the unit and to the treatment nurse utilizing the skin/body alert sheet... Minimize resident's skin to moisture... Residents must be checked at least every 2 hours, changed and given perineal/incontinent skin care..."</p> <p>2. Medical record review for Resident #54 documented an admission date of 11/8/11 with diagnoses of Renal Insufficiency, Coronary Artery Disease, Hypertension, Congestive Heart Failure and Obesity. Review of the nursing admission assessment dated 11/8/11 documented, "...No open areas... abrasion/bruising old... SKIN RISK ASSESSMENT... Score-11, Scores above 8 = [indicate] HIGH RISK..." Resident #54 was assessed as a high risk for developing skin breakdown, yet no preventative measure were put in place to prevent the development of pressure ulcers.</p> <p>Review of the admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 11/14/11 documented in Section G for activities of daily living (ADL) assistance, Resident #54 was independent in bed mobility, supervision with transfers, extensive assist with dressing, independent in eating and one person assist with toileting. The MDS documented in Section M Skin Condition, Resident #54 had no pressure ulcers..." Review of the MDS with an ARD of 2/2/12 Section M Skin Conditions documented Resident #54 had no pressure ulcers. Review of the MDS with an ARD of 3/9/12 Section M Skin Conditions, Resident #54 had three Stage 2 pressure ulcers.</p> <p>Review of skin assessments for Resident #54</p>	F 314			

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F 314	<p>Continued From page 181</p> <p>documented the following:</p> <p>a. 11/23/11 - "...Skin on limbs mottled and bruised easily... Score: 12..."</p> <p>b. 12/16/11 - "...thin paper like skin c [with] mottling [symbol for and] bruising... Score: 12..."</p> <p>c. 12/21/11 - "...Paper thin like skin mottling Bruising noted... Score: 12..."</p> <p>d. 2/1/12 - "...bruised easily, skin on limbs mottled. No skin breakdown noted...Score: 12..."</p> <p>e. 2/26/12 - "...Resident c deep tissue injury to buttocks (see wound documentation) Multiple old bruises to upper & [and] lower exts [extremities]. Old scar to face..."</p> <p>The facility was unable to provide documentation of weekly skin assessments for 2/8/12, 2/15/12 and 2/22/12.</p> <p>Review of the care plan dated 3/15/12 documented, "...Impaired skin integrity r/t [related/to] Stage II to the sacral area and Rt. [right] and Left buttocks... Weekly skin assessments per Charge Nurse..."</p> <p>Review of the weekly pressure ulcer records for Resident #54 documented the following:</p> <p>a. 3/1/12, 3/5/12 and 3/15/12 - "...DATE OF ONSET: 3/1/12... SITE LOCATION: Sacral... STAGE 2 was checked... Size IN CM [centimeters] 10cm x [by] 5 cm... DEPTH < [less than] 0.1cm..."</p> <p>b. 3/19/12 - "DATE OF ONSET 3/1/12... SITE LOCATION: Sacral... STAGE 4 was checked... SIZE IN CM 12cm x 8cm... DEPTH 0.5cm..." The sacral pressure ulcer had deteriorated to a Stage 4.</p> <p>c. 3/30/12 - "STAGE 4 was checked... DEPTH <0.1cm..."</p> <p>d. 4/5/12 - "...DATE OF ONSET 4/5/12... SITE</p>	F 314			

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F 314	Continued From page 182 LOCATION (R) [right] hip... STAGE 2 was checked... SIZE IN CM 4cm x 3cm <0.1cm..." e. 4/9/12 - "...DATE OF ONSET: 4/9/12... SITE/LOCATION: (L) [left] hip... STAGE 3 was checked... SIZE IN CM 3cm x 4cm < 0.2cm..." Resident #54 developed an avoidable pressure ulcer that was a stage III before the facility had identified it's presents. 4/9/12 - "...DATE OF ONSET: 4/9/12 SITE/LOCATION: (L) trochanter... STAGE 2 was checked... SIZE IN CM 1/2cm x 2cm DEPTH <0.1cm... WOUND BED-Dk [dark] Red/Purple..." f. 4/11/12 - "...DATE OF ONSET 4/5/12... SITE LOCATION (R) hip... STAGE 2 was checked... SIZE IN CM 4cm x 3cm <0.1cm..." g. 5/3/12 - "...DATE OF ONSET 4/5/12... SITE LOCATION (R) hip... STAGE 2 was checked... SIZE IN CM 4cm x 3cm <0.1cm..." 5/3/12 - "...DATE OF ONSET: 4/9/12... SITE/LOCATION: (L) hip... STAGE 3 was checked... SIZE IN CM 3cm x 4cm... DEPTH <0.2... WOUND BED BROWN..." 5/3/12 - "...DATE OF ONSET: 4/9/12 SITE/LOCATION: (L) trochanter... STAGE 2 was checked... SIZE IN CM 1/2cm x 2cm DEPTH <0.1cm... WOUND BED-Dk Red/Purple..." h. 5/30/12 - "...DATE OF ONSET 4/5/12... SITE LOCATION Right hip... STAGE 3 was checked... SIZE IN CM 5cm x 4 cm... DEPTH 0.5cm..." This pressure ulcer had deteriorated to a stage III since 4/5/12. 5/30/12 " ...DATE OF ONSET: 4/9/12... SITE/LOCATION: Left hip... STAGE unstageable was checked... SIZE IN CM 8cm x 7.5 cm... DEPTH 2cm... WOUND BED-Black... SURROUNDING TISSUE-Black..." This pressure ulcer had deteriorated since the development on 4/9/12. 5/30/12 - "...DATE OF ONSET: 4/9/12 SITE/LOCATION: Left trochanter... STAGE unstageable was checked... SIZE IN CM 3cm x	F 314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 314	<p>Continued From page 183</p> <p>13cm DEPTH 1cm... WOUND BED Black... SURROUNDING SKIN COLOR Black..." This pressure ulcer had deteriorated since the development on 4/9/12.</p> <p>i. 6/7/12 - "...DATE OF ONSET 4/5/12... SITE LOCATION Right hip... STAGE 3 was checked... SIZE IN CM 5cm x 4 cm... DEPTH 0.5cm..." This pressure ulcer had deteriorated since the development on 4/5/12.</p> <p>6/7/12 - "...DATE OF ONSET: 4/9/12... SITE/LOCATION: Left hip... STAGE unstageable was checked... SIZE IN CM 8cm x 7.5 cm... DEPTH 2cm... WOUND BED-Black... SURROUNDING TISSUE-Black..." This pressure ulcer had deteriorated since the development on 4/9/12.</p> <p>j. 6/14/12 - "...DATE OF ONSET 4/5/12... SITE LOCATION Right hip... STAGE 3 was checked..." This pressure ulcer had deteriorated since the development on 4/9/12.</p> <p>All of Resident #54's pressure ulcers were avoidable and in house acquired.</p> <p>Review of treatment nurse in-house skin assessments documented the following:</p> <p>a. 2/26/12 - "...DATE NOTICE-2/26/12... DESCRIPTION OF WOUNDS - Resident c deep tissue injury to sacral right buttocks and left buttocks. Sacral size 11 cm x 8 cm c opening & center of wound bed deep dark red c bright red surrounding tissue. Right buttocks size 6 cm x 5.5 cm [symbol for zero] opening center of wound bed c dark red tissue and surrounding tissue bright red tissue. Left buttocks size 6cm x 5cm c center of ulcer dark red tissue & surrounding tissue bright red no drainage or odor noted to either ulcer... TREATMENT-Apply Xenaderm to entire buttocks BID [twice daily]..."</p>	F 314			

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

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F 314	<p>Continued From page 184</p> <p>b. 4/9/12 - "...description of wounds: Resident has several wounds located on (L) hip, (L) trochanter and (L) mid back. (L) hip is 3cm x 4cm x 0.1cm no odor or drainage (L) mid back is ½ x 1cm < 1.0 cm c black eschar. (L) trochanter is ½ cm x 2cm c slough area in center... TREATMENT: (L) hip clean c N/S [Normal Saline] pat dry & apply duoderm [symbol for change] q [every] 3 days (L) mid back clean c NS pat dry & apply silver nitrate q day until healed. (L) trochanter clean c N/S apply Xenaderm oint [ointment] & change q day. Clinitron bed to promote healing of all ulcers..."</p> <p>During an interview at the 2nd Magoffin nurses' station on 9/19/12 at 7:30 AM, Nurse #8 was asked about skin assessments for residents. Nurse #8 stated, "Skin assessments were done weekly in February and March [2012]. In April [2012] they were done twice a month." Nurse #8 was then asked about Resident #54's pressure ulcers. Nurse #8 stated, "He developed them [pressure ulcers] after he came here..."</p> <p>The facility failed to put preventative measures in place to prevent the development of pressure ulcers; assess/accurately assess skin conditions, and failed to identify a pressure ulcer until it was a stage 3 pressure ulcer which placed Resident #54 in IJ. This stage 3 pressure ulcer was an avoidable in-house acquired pressure ulcer which deteriorated during his stay at the facility.</p> <p>3. Medical record review for Resident #74 documented an admission date of 2/18/10 with diagnoses of Alzheimer's Disease, Dysphagia, History of Cerebrovascular Accident, Gastro Esophageal Reflux Disease, Hypertension, Depression, and Lung Cancer with Metastasis.</p>	F 314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 314	<p>Continued From page 185</p> <p>Review of the weekly pressure ulcer records documented the following:</p> <p>a. An onset date of 5/31/12 - Stage II left hip pressure sore 1 cm x 1 cm <0.1 depth.</p> <p>b. 6/7/12 - Stage II left hip pressure sore 1 cm x 1 cm <0.1 depth.</p> <p>c. 6/13/12 - Stage II left hip pressure sore 1 cm x 0.8 cm <0.1 depth.</p> <p>The facility was unable to provide documentation of weekly skin assessments from 6/13/12 until 8/20/12.</p> <p>d. 8/20/12 - Stage II left hip pressure sore 2 cm x 2 cm <0.1 depth. This pressure ulcer had deteriorated since 6/13/12.</p> <p>e. 8/27/12 - Stage II left hip pressure sore 2 cm x 1.5 cm <0.1 depth.</p> <p>The facility is unable to provide documentation of skin assessment since 8/27/12.</p> <p>Review of the quarterly MDS dated 7/11/12 documented Resident #74 required extensive assistance and was total dependent for bed mobility, transfers, dressing, eating, toilet use and personal hygiene. This same MDS in Section M for skin conditions documented Resident #74 had two Stage II pressure ulcers.</p> <p>Review of the physician's orders dated 8/15/12 documented, "...clean Lt [left] hip area [symbol for with] pat dry and cover [symbol for with] duoderm. [symbol for change] q [every] 3 days..."</p> <p>Review of the care plan dated 8/16/12 documented, "...Problem Impaired skin integrity... Approach Frequency... Weekly skin assessments per Charge Nurse... Administer treatment as ordered..."</p>	F 314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 314	<p>Continued From page 186</p> <p>Review of the Treatment Administration Record (TAR) for 9/1/12 through 9/30/12 revealed treatment for pressure ulcers was not provided as ordered on 9/1/12, 9/7/12, 9/10/12, or 9/14/12 through 9/17/12.</p> <p>Observations in Resident #74's room on 9/17/12 at 3:30 PM, Nurse #5 removed the duoderm dressing from Resident #74's left hip for assessment of the pressure ulcer. The pressure ulcer was assessed to be a Stage III with measurements of approximately 2 cm in diameter, full thickness of skin loss with reddish drainage noted on duoderm. The pressure ulcer has deteriorated to a Stage III since the development as a Stage II.</p> <p>During an interview in Resident #74's room on 9/17/12 at 3:30 PM, Nurse #5 was asked what was the stage of the pressure sore. Nurse #5 stated, "...it's a Stage III..."</p> <p>During an interview in the MDS office on 9/18/12 at 10:43 AM, Nurse #4 was asked who is responsible to measure and stage pressure ulcers. Nurse #4 stated, "...the treatment nurse is suppose to measure the wounds weekly... The nurses on the floor are not supposed to measure or stage [pressure ulcers]..." Nurse #4 was asked who does the measurements and staging when the treatment nurse is working the floor instead of providing treatments. Nurse #4 stated, "...it has been three weeks to one month since the other treatment nurse has been here..."</p> <p>The facility was unable to provide documentation the pressure ulcer treatments had been provided</p>	F 314			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 314	<p>Continued From page 187</p> <p>as ordered or that weekly pressure ulcer assessments had been done as defined in the facility's policy. The facility staff failed to assess/accurately assess or provide care and treatments which resulted in an IJ when Resident #74 developed an avoidable in-house acquired pressure ulcer that deteriorated.</p> <p>4. Medical record review for Resident #82 documented an admission date of 1/5/11 with diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus Type I, Hypertension, Chronic Renal Disease, Bipolar Disorder, Hypothyroidism, Gout, Obesity, and Defiant Behavior. Review of the annual minimum data set (MDS) dated 6/14/12 documented in section C for cognitive patterns that Resident #82 was scored as "15" indicating the resident is cognitively intact.</p> <p>Review of the care plan dated 6/20/12 documented, "...POTENTIAL FOR PRESSURE ULCERS RELATED TO INCONTINENCE, IMPAIRED MOBILITY AND OBESITY... Assess record and report any blisters redness soft/mushy areas to charge nurse/MD [Medical Doctor]... Assess resident skin condition weekly... Use pressure reduction devices and position devices as needed... Turn and reposition resident q [every] 2 hours and prn [as needed]... Notify physician as soon as possible of redness, blisters or breakdown for proper initiation of treatment... 9/4/12 Right upper Inner thigh... Administer treatment as ordered by the physician. Ointments/Creams... Weekly skin assessments per Charge Nurse... Treatment Nurse to evaluate effectiveness of treatment and notify physician of changes..."</p>	F 314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 314	Continued From page 188 Review of a physician's order dated 8/12/12 and timed 2p [PM] documented, "...Clean area to (R) upper inner thigh [symbol for with] NS pat dry and apply xenaderm oint [ointment] and cover [symbol for with] dry dressing every day..." Review of the TAR dated 9/1/12 through 9/30/12 documented, "...Clean area to (R) upper inner thigh [symbol for with] NS [normal saline], pat dry and apply xenaderm oint and cover [symbol for with] dry dressing qd [every day]..." Documentation on the TAR revealed the treatment was started on 9/4/12. There was no documentation the treatment was provided as ordered on 9/6/12, 9/7/12, 9/8/12 or 9/12/12. During an interview in Resident #82's room on 9/13/12 at 4:20 PM, Resident #82 was asked if she was changed timely when wet with urine. Resident #82 stated, "Sometimes they do. Depends on who is working... They tell me I have sores on my bottom. It hurts sometimes." During an interview in Resident #82's room on 9/14/12 at 8:51 AM, Resident #82 stated, "My call light is broke. I had to use my cell phone to call my nurse last night. I called [named Nurse #11] and I called the head nurse [Nurse #16] later. [Named Nurse #16] said there was nothing she could do about them not changing me because it was on 3 to 11 shift and they [staff] were gone. She [Nurse #16] didn't get anybody to change me. I laid here awhile and then I went to sleep. No one came back until 6 [6:00 am] this morning. I was changed then. I was wet for a long time. I told you they didn't always change me."	F 314			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 314	<p>Continued From page 189</p> <p>Observations in Resident #82's room on 9/14/12 at 10:24 AM, revealed Resident #82 had three stage II pressure ulcers; an open area on the left inner thigh, an open area on the right inner thigh, and an open area on the right buttock. There was no dressing on any of the wounds.</p> <p>Resident #82 was left wet with urine during the 3/11 shift on 9/13/12 until 6:00 AM, resulting in the development of two new avoidable in house acquired stage II pressure ulcers; one on the left inner thigh and one on the right buttocks.</p> <p>Review of the weekly pressure ulcer record dated 9/14/12 documented, "...DATE OF ONSET: 9-14-12 SITE/LOCATION: R buttock... Stage 2 SIZE IN CM [centimeters] (LENGTH X WIDTH) 2.0 X 2.0 DEPTH 0..." The new pressure ulcer on the L upper thigh was not described on the pressure ulcer record.</p> <p>Review of a nurse's note dated 9/14/12 at 6:00 PM documented, "Stage II area on Rt buttock and small open areas on R and L inner thigh c [with] appearance of Stage II... New orders noted at this time for R & L inner thigh & R buttock..."</p> <p>Review of a physician's order dated 9/14/12 and timed 6:05 PM documented, "Clean Rt buttock c NS pat dry and apply duoderm Change q Monday & Thursday & PRN [as needed] as needed... Clean right & left inner thigh areas c NS and apply xenaderm q shift..."</p> <p>During an interview at the nurses' station on 1st McRee on 9/14/12 at 4:25 PM, Nurse #2 stated, "I looked at her [Resident #82] yesterday [9/13/12] and tended to the area on the right inner thigh.</p>	F 314			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 314	<p>Continued From page 190</p> <p>There was nothing else. No other areas. If there is an area found it would be put on the log sheet and in the physician's communication book." There was no documentation of any report in the physician's communication book or the treatment log sheet.</p> <p>Review of the Medication Administration Record (MAR) dated 9/1/12 through 9/30/12 documented, "...Clean R & L inner thigh c NS & apply xenaderm q shift..." There was no documentation the xenaderm was applied as ordered from 9/14/12 through 9/17/12.</p> <p>Observations in Resident #82's room on 9/17/12 at 11:20 AM, revealed Resident #82 lying in bed. Nurse #1 and Certified Nursing Assistant (CNA #1) repositioned the resident to her left side. Resident #82 was wet with urine. There was no dressing covering the Stage II pressure ulcer on the resident's right buttock.</p> <p>During an interview in room 420 on 9/17/12 at 11:22 AM, Nurse #1 was asked if the Stage II ulcer on the Resident #82's right buttock had a dressing applied as ordered. Nurse #1 stated, "It's not on. This is it." The duoderm dressing was rolled up and laying on the incontinent pad under Resident #82's right thigh.</p> <p>During an interview in the conference room on 9/17/12 at 4:18 PM, Nurse #3 stated, "The Skin Evaluation sheet is supposed to be done monthly." Nurse #3 was asked if the weekly charting of the skin evaluation was completed for Resident #82. Nurse #3 reviewed the medical record and stated, "They're [nurses] not doing it [skin evaluation]. In this nurse's notes I don't see</p>	F 314			

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F 314	<p>Continued From page 191 it."</p> <p>During an interview on 9/18/12 at 8:32 AM, Resident #82 was asked if the dressing was applied to the wound on her right buttock and ointment applied to the wounds on 9/17/12. Resident #82 stated, "No ma'am. Nobody came to put a dressing on me yesterday and not yet today."</p> <p>During an interview in the hallway outside the conference room on 9/18/12 at 8:45 AM, the Vice President (VP) was asked if the treatment nurse was here on 9/17/12 and performed the treatments. The VP stated, "No, she didn't come. The agency nurse did some treatments. The ones she got around to doing. I don't know how many or which ones."</p> <p>The facility was unable to provide documentation that pressure ulcer treatments had been provided as ordered or that the pressure ulcers were assessed weekly as defined in the facility's policy. The resident was left unattended and wet with urine during the night shift of 9/13/12 resulting in two new avoidable in house acquired stage II pressure ulcers developing on the left inner thigh and on the right buttocks. The facility's staff failed to assess/accurately assess or provide care and treatments which resulted in an IJ when Resident #82 developed avoidable in house acquired pressure ulcers that deteriorated.</p> <p>5. Medical record review for Resident #60 documented an admission date of 3/5/10 with a readmission date of 1/18/11 with diagnoses of Diabetes Mellitus, Essential Hypertension, Senile Dementia, Paraplegia, Seizure Disorder,</p>	F 314			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 314	<p>Continued From page 192</p> <p>Gastroesophageal Reflux Disease, Thyroid Disease, Gastrointestinal Bleed and Peripheral Vascular Disease.</p> <p>Review of a physician's order dated 12/3/11 documented, "...CLEAN RT HEEL W [with] / NS, PAT DRY & WIPE W/ ALCOHOL WIPE & COVER W/ 4X4'S, ABD [abdominal] PAD & KERLIX WRAP DAILY..." Review of a physician's order dated 10/26/11 documented, "...CLEAN LT HEEL WOUND W/ NS, APPLY ALCOHOL WIPE DRESS W/PAD & KERLIX WRAP CHANGE EVERY OTHER DAY..." Review of a physicians order dated 6/18/12 documented, "...D/C [discontinue] all previous wound care orders. Clean right lat. [lateral] thigh [symbol for with] NS, pat dry & apply opsite & change Q [every] 3 days until resolved.</p> <p>Review of the "WEEKLY PRESSURE ULCER HEALING RECORD" documented, "...DATE OF ONSET 10/26/11 SITE/LOCATION (L) heel... DATE 5/3/12 STAGE... [check mark in box] Unstageable size in cm (length x width) 1/2 cm X 1/2 cm DEPTH < 0.1 cm..."</p> <p>Review of the treatment record dated 12/1/11 through 12/31/11 revealed there were no treatments documented as being provided as ordered for the left heel pressure ulcer on 12/5, 12/7, 12/9, 12/11, 12/13, 12/15, 12/17, 12/22, 12/24, 12/26, and 12/28/11. There were no treatments documented as being provided as ordered for the right heel pressure ulcer on 12/5, 12/7, 12/9, 12/11, 12/13, 12/15, 12/17, 12/23, 12/25, 12/27, and 12/29/11.</p> <p>Review of the treatment records dated 1/1/12</p>	F 314			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 314	<p>Continued From page 193</p> <p>through 1/31/12 revealed there were no treatments documented as being provided as ordered for the left heel and the right heel pressure ulcers on 1/30 and 1/31/12.</p> <p>Review of the treatment record dated 2/1/12 through 2/29/12 revealed there were no treatments documented as being provided as ordered for the left heel pressure ulcer on 2/13, 2/15, 2/22, 2/24, 2/26, and 2/28/12. There were no treatments documented as being provided as ordered for the right heel pressure ulcer on 2/21, 2/22, 2/23, 2/24, 2/26, 2/27, and 2/28/12.</p> <p>Review of the treatment record dated 3/1/12 through 3/31/12 revealed there were no treatments documented as being provided as ordered for the left heel pressure ulcer on 3/1, 3/7, 3/9, 3/12, 3/14, 3/16, and 3/20/12. The treatment record dated 3/1/12 through 3/31/12 documented the pressure ulcer on the right heel had "Resolved..."</p> <p>Observations in Resident #60's room on 9/17/12 at 10:05 AM, revealed Resident #60's left inner heel had a small area of purplish skin that appears to be blistered or wrinkled. There was a blue maxi float mattress on the bed.</p> <p>Observations in Resident #60's room on 9/17/12 at 11:30 AM, revealed a beige regular mattress was placed on the bed. The replacement mattress was not a pressure relieving mattress.</p> <p>During an interview in the conference room on 9/17/12 at 2:50 PM, Nurse #3 verified the empty spaces on the treatment record indicated the treatments were not provided as ordered for the</p>	F 314			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 314	Continued From page 194 months of December 2011 and January, February, and March 2012. During an interview in the hallway on 2nd Magoffin across from the nurses' station on 9/18/12 at 8:30 AM, Nurse #2 was asked if Resident #60 was on any preventative measures when he was admitted on 3/5/10. Nurse #2 stated, "...He had wounds to his heels that resolved. Then he developed unstageable wounds to his heels on 10/11..." During an interview in the medical records office on 9/19/12 at 8:30 AM, the medical records personnel stated, "...They're not there [referring to documented weekly skin assessments]..." During an interview at the 1st McRee nurses' station on 9/19/12 at 8:35 AM, Nurse #4 stated, "...Yes, they should have weekly documentation about skin assessments whether it is 7-3, 3-11 or 11-7 shift... It [skin assessments] should be done weekly..." Nurse #4 verified there were no weekly assessments completed for Resident #60 from January 2012 to September 2012.	F 314			
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 318	Continued From page 195 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, it was determined the facility failed to ensure that residents with limitations in range of motion (ROM) received care and treatment to prevent further decline in ROM for 3 of 10 (Residents #21, 24, and 43) sampled residents of the 38 residents included in the stage 2 review. The findings included: 1. Medical record review for Resident #21 documented an admission date of 1/13/99 with diagnoses of Late Effects of Cerebrovascular Disease, Hemiplegia affecting Dominant Side Right, Aphasia, Dementia, Depression, Hypertension, Gastro Esophageal Reflux Disease (GERD) and Adult Failure to Thrive. The nursing re-admission assessment dated 10/12/06 documented, "...Contractures - specify Rt [right] hand..." Review of the annual minimum data set MDS dated 4/11/12 and the quarterly MDS dated 7/4/12 documented in section G0400 for functional limitation in ROM documented Resident #21's upper and lower extremity was impaired on one side. Review of the care plan dated 7/10/12 documented, "Problem... Potential for increased contractures... Approach... 3. Perform active and passive ROM during ADL's [activities of daily living] as indicated..."	F 318			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 318	<p>Continued From page 196</p> <p>Review of the nursing care ADL's dated 7/1 through (-) 7/31/12 documented no range of motion on 7/4/12, 7/16/12, 7/18/12, 7/19/12, 7/20/12, 7/25/12, 7/25/12 and 7/27/12. Review of the nursing care ADL's dated 8/1- 8/31/12 had no range of motion documented as being done on 8/2/12, 8/4/12, 8/5/12, 8/6/12, 8/9/12, 8/16/12, 8/17/12, 8/18/12, 8/19/12, 8/20/12, 8/24/12, 8/27/12, 8/28/12 and 8/31/12.</p> <p>Observations in the first magoffin dining room on 9/10/12 at 5:10 PM, revealed Resident #21 eating supper, with a right hand contracture present with no splint in place.</p> <p>Observations of a seating area of first magoffin on 9/11/12 at 7:58 AM, revealed Resident #21 seated in his wheelchair, with a right hand contracture present with no splint in place.</p> <p>Observations of a seating area of first magoffin on 9/12/12 at 8:30 AM, revealed Resident #21 seated in his wheelchair, with a right hand contracture present with no splint in place.</p> <p>During an interview at the first magoffin nurses' station on 9/11/12 at 8:21 AM, Nurse #6 was asked if Resident #21 had a splint in place or received range of motion services for his contracture. Nurse #6 stated, "No."</p> <p>2. Medical record review for Resident #24 documented an admission date of 7/19/12 with diagnoses of Diabetes Mellitus, Peripheral Vascular Disease, Hypertension, Congestive Heart Failure, Urinary Tract Infection, Cerebrovascular Accident, and Dementia with Behaviors. Review of the MDS with an</p>	F 318			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 318	<p>Continued From page 197</p> <p>assessment reference date (ARD) of 4/12/12 and updated 7/5/12 revealed section G (A and B) were coded as 1 indicating the resident had limitations in ROM of upper and lower extremities on one side. Review of the care plan dated 7/12/12 did not address the resident's limitations in ROM.</p> <p>Observations in the dayroom on 9/10/12 at 10:30 AM, revealed Resident #24 seated in a wheelchair with his left arm in a flexed position.</p> <p>Observations on 2nd magoffin hallway on 9/10/12 at 4:50 PM, and on 9/11/12 at 8:45 AM, revealed Resident #24 seated in a wheelchair with his left arm in a flexed position.</p> <p>During an interview at the 2nd magoffin nurses' station on 9/10/11 at 11:30 AM, Nurse #8 confirmed that Resident #24 did not wear a splint and was not receiving ROM exercises.</p> <p>3. Medical record review for Resident #43 documented an admission date 12/22/09 with diagnoses of Vascular Dementia with Delusions, Hypertension, Diabetes Mellitus, Alcohol Abuse, Convulsions, Cerebrovascular Accident, and Left Hemiparesis. Review of the annual MDS dated 11/23/11 and the most recent quarterly MDS dated 8/1/12 documented that Resident #43 has functional limitation in range of motion (ROM) on one side for the upper and lower extremities.</p> <p>Review of the care plan dated 11/29/11 and revised 8/7/12 documented, "...3. SELF CARE DEFICIT IN ADL'S R/T [related to] IMPAIRED MOBILITY... ROM TO ALL EXTREMITIES AS SCHEDULED..."</p>	F 318			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 318	<p>Continued From page 198</p> <p>Review of the restorative and rehabilitation nursing assessment dated 8/9/12 documented, Resident #43 was included in the facility's nursing maintenance and restorative program.</p> <p>Review of the nursing monthly summary dated March through July 2012 documented that Resident #43 received rehabilitation/restorative services at least 15 minutes 3 times a week. Review of nursing monthly summary dated August 2012 had ROM exercises crossed off. Review of the nursing care ADL's dated March through September 2012 had ROM crossed out.</p> <p>Observations in the activity room on 9/12/12 at 10:22 AM, revealed Resident #43 participating in exercises. Resident #43 performed the exercises with both legs and right arm, but not with his left arm.</p> <p>Observations in room 109 on 9/18/12 at 7:45 AM, revealed Resident #43 seated on the side of the bed eating breakfast using his right hand.</p> <p>During an interview at the 1st magoffin nurses' station on 9/11/12 at 8:10 AM, Nurse #6 was asked if Resident #43 had a contracture defined as a condition of fixed high resistance to passive stretch of a muscle. Nurse #6 stated, "Yes ...left hand." Nurse #6 was then asked if Resident #43 received ROM services or had a splint device in place. Nurse #6 stated, "No."</p> <p>During an interview at the 1st magoffin nurses' station on on 9/18/12 at 8:15 AM, Certified Nursing Assistant (CNA) #14 (who is responsible for the restorative program) was asked if</p>	F 318			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 318	Continued From page 199 Resident #43 received rehabilitation or restorative services. CNA #14 stated, "...I don't see [named resident]..." During an interview in the conference room on 9/18/12 at 8:50 AM, Nurse #4 was asked if the Resident #43 was receiving ROM exercises. Nurse #4 stated, "...it should be documented..." Nurse #4 then reviewed the medical record and stated, "...I don't see an order to discontinue ROM... that's not good if it's not documented..."	F 318			
F 319 SS=J	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on medical record review, it was determined the facility failed to ensure psychiatric services were provided for 2 of 38 (Residents #116 and 68) sampled residents. The facility's failure to assess and provide the necessary care and services to address the behaviors of the resident displaying mental difficulty placed Resident #116 in an immediate jeopardy (IJ). The Administrator, Facility Consultant, Vice President and the Nursing Supervisor were informed of this IJ on 9/20/12 at 6:00 PM. This IJ was considered present and ongoing at the time of exit. The findings included:	F 319			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 319	<p>Continued From page 200</p> <p>1. Medical record review for Resident #116 documented an admission date of 9/8/11 with diagnoses of Alzheimer's Dementia, Aggressive Behaviors, Coronary Artery Disease, Diabetes Mellitus, Hypertension, and Congestive Heart Failure. Review of the Minimum Data Set (MDS) with an assessment reference date (ARD) of 3/1/12 section E-Behaviors, E0200-Behavioral Symptoms-Presence and Frequency was coded as 1 indicating presence of physical behavioral symptoms directed toward others occurring 1 to 3 days. Section E0800-Rejection of Care-Presence and Frequency was coded as 2 indicating this behavior had occurred 4 to (-) 6 days, but less than daily. Review of the MDS with an ARD of 8/17/12 section E-Behaviors, E0800 Rejection of Care-Presence and Frequency was coded as 1 indicating this behavior occurred 1-3 days.</p> <p>Review of nurses notes documented the following:</p> <p>a. 10/28/11 - "...refused dinner... refuses skin assessment by staff... stays in room with door shut and privacy curtains pulled..."</p> <p>b. 11/22/11 - "...refused skin assessment... stays in the room with door closed and privacy curtain pulled..."</p> <p>c. 2/4/12 - "...Resident very agitated and restless @ [at] dinner time towards staff and other residents. Resident refused to eat dinner, attempted to hit nurse and another resident... Aggressive @ times..."</p> <p>d. 3/20/12 - "...Aggressive towards other resident and staff..."</p> <p>e. 4/9/12 - "...confusion noted @ times with agitation..."</p> <p>f. 4/11/12 - "...resident refused this nurse's request to perform a head to toe skin assessment</p>	F 319			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 319	<p>Continued From page 201</p> <p>today..."</p> <p>g. 4/20/12 - "...Resident stays in the room with door closed often. Resident encouraged to socialize with other residents. Agitated @ times..."</p> <p>h. 7/18/12 - "...Attempted to notify RP [responsible party]... not to give resident large sum of money in order not to buy stuff from other residents. Resident has been purchasing stuff from another residents..."</p> <p>i. 8/9/12 - "...Refused blood draw x [times] 2..."</p> <p>j. 9/5/12 - "...Resident hit another resident in the hallway on the 1st floor. No injuries noted to either resident. Resident stated, "hell yeah I hit the motherfucker" Im [I'm] sick of that motherfucker stealing shit from everybody." I tried to knock his motherfucking ass out of the w.c. [wheelchair]." Explained to resident he can not hit other residents. Resident [#116] stated "I'm gonna beat his ass if he steals from me again... Social worker notified and here to speak with residents. MD [Medical Doctor] notified and no new orders noted..."</p> <p>Review of Resident #116's care plan dated 3/1/12 and 8/23/12 had no documented aggressive or reclusive behaviors, refusals of care, social service referrals or mental health referrals.</p> <p>Review of the social service notes from January 2012 to September 2012 there were no documented aggressive or reclusive behaviors, refusals of care or mental health referrals.</p> <p>The nursing behavior assessment dated 9/21/11 had no documented behavior issues. There were no other behavior assessments documented since 9/21/11.</p>	F 319			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 319	<p>Continued From page 202</p> <p>The Director of Nursing and the Minimum Data Set Nurse were not available for interview to provide confirmation of the behaviors during the last four days of the survey.</p> <p>The facility was unable to provide monthly pharmacy reviews from January 2012 through August 2012.</p> <p>Mental health documented visits on 11/15/11 and 12/6/11 with no documented problems. Abnormal involuntary movement scale (AIMS) assessment was done 12/6/11 with no problems noted. There has been no AIMS completed since 12/6/11.</p> <p>The facility's failure to assess and provide the necessary care and services to address the behaviors of the resident displaying mental difficulty placed Resident #116 in an immediate jeopardy.</p> <p>2. Medical record review for Resident #68 documented an admission date of 1/22/10 with diagnoses of Cerebrovascular Accident, Hemiplegia, Hypertension, Musculoskeletal Disorder of the Neck, Osteoarthritis, Renal Insufficiency, Diabetes Mellitus, Gastroenteritis, Hypocholesterolemia, Callosities, Frequent Urination, Degenerative Joint Disease, and Epilepsy.</p> <p>Review of the nurses notes documented the following: a. 5/11/12 at 11:00 AM - "...found on second floor pulling down linen... staff said that he urinated on linen... Pt [patient] states "I was looking for a diaper, I didn't do that. I just pee on myself... told</p>	F 319			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 319	Continued From page 203 him to ask staff on his floor... understands and won't do it again..." b. 5/17/12 at 11:00 AM - "Activity reported that resident had been informed multiple times to stop going in smoke... and going out doors and coming down handicap ramp... he just rode away from me in his wheelchair..." c. 7/11/12 at 11:00 AM - "...taking liners out of garbage cans..." d. 8/14/12 at 5:00 AM - "Resident continually taking other residents belongings personal items and clothing... going to other units taking or stealing items... going through personal things..." Review of the care plan dated 12/27/11 and updated 3/20/12, 6/12/12 and 9/4/12 did not address Resident #68's behaviors. The facility had not provided treatment and services to assist with the behaviors exhibited by Resident #68.	F 319			
F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure - that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on review of the Federal Drug Administration (FDA) guidance concerning side rails as entrapment hazards, review of incident	F 323			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 323	Continued From page 204 reports, review of the facility's census and condition (Centers of Medicare / Medicaid Services (CMS) 672) dated 9/10/12, policy review, medical record review, observation and interview, it was determined the facility failed to ensure that safety measures were implemented to prevent entrapment hazards associated with the use of side rails for 4 of 5 (Residents #6, 13, 84 and 122) residents at risk for entrapment in siderails, which placed these four residents in immediate jeopardy (IJ). The facility failed to ensure a resident at risk for falls had interventions implemented after each fall to prevent further falls for 1 of 3 (Resident #23) sampled residents reviewed with falls, which placed Resident #23 in IJ. The facility failed to ensure the environment was free from accident hazards when 33 of 97 (per CMS 672) ambulatory residents could come and go unsupervised from their unit and enter through 4 of 4 doors to have access to 2nd McRee (a closed unit) and enter through 2 of 3 doors to 3rd Magoffin that allowed access to stairways and an elevator to enter the closed dark units of 2nd McRee and 3rd Magoffin. The ability of residents to enter unoccupied areas of the building that are not staffed and have access to the outside, via elevators, stairs and doors could lead to elopement in a high crime area, with access to a major highway less than (<) 500 yards from the facility and a functioning railroad yard with multiple train tracks < than 200 yards from the facility; falls with no ability to call for help and the capability of anyone entering the building through non secured doors placed all the 97 residents at risk for immediate jeopardy. The facility failed to provide working smoke detectors for 4 of 68 (room 401, 403, 414 and 219) resident rooms.	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 323	<p>Continued From page 205</p> <p>The Administrator, Vice President and Director of Nursing (DON) were informed of this IJ identified on 9/13/12 at 10:30 AM. The facility provided surveyors with a written response on 9/14/12 at 5:30 PM for their accident prevention. This written response was determined to be unacceptable on 9/14/12. The IJ was considered present and ongoing at the time of exit.</p> <p>The findings included:</p> <p>A. SIDE RAILS</p> <p>1. Review of the FDA Safety Alert: Entrapment Hazards with Side Rails alert notice dated August 23, 1995 documented, "...This Safety Alert concerns entrapment hazards associated with the use of ...side rails ...All reported entrapments occurred in one of the following ways ...1. through the bars of an individual side rail; 2. through the space between split side rails; 3. between the side rail and mattress; or 4. between the headboard or footboard, side rail, and mattress... FDA recommends the following actions to prevent deaths and injuries from entrapment in... side rails: Inspect all ...bed frames, bed side rails, and mattresses as part of a regular maintenance program to identify areas of possible entrapment. Regardless of mattress width, length, and/or depth, alignment of the bed frame, bed side rail, and mattress should leave no gap wide enough to entrap a patient's head or body... Be alert to replace mattresses and bed side rails with dimensions different than the original equipment supplied or specified by the bed frame manufacturer... Not all bed side rails, mattresses, and bed frames are interchangeable... Additional safety measures should be considered for</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 323	<p>Continued From page 206</p> <p>patients identified as high risk for entrapment. Such patients include those with altered mental status (organic or medication related) or general restlessness..."</p> <p>Review of the "Guidance for Industry and FDA Staff" guidelines dated March 10, 2006 documented, "...Bed System Dimensional and Assessment Guidance to Reduce Entrapment... evaluating the dimensional limits of the gaps in ...beds is one component of an overall assessment and mitigation strategy... most vulnerable to entrapment are elderly patients... especially those who are frail, confused... incontinent, experience pain or who get out of bed and walk unsafely without assistance... one component of a bed safety program includes a comprehensive plan for patient assessment... FDA recommends... a risk benefit analysis to reduce entrapment... FDA using a head breadth dimension 4 ¾ inches [""] as the basis for its dimensional recommendations... FDA recommends space enough to prevent dimensional neck entrapment... head entrapment under the rail less than 4 ¾ inches... in some positions the potential for entrapment exist when the deck is articulated... movement of the bed deck is known as articulation... we recommend that patient assessment procedures be used to assess the risk entrapment when clinical care is provided..."</p> <p>Review of the facility's side rails policy documented, "...Assess siderail fit on the bed prior to use to determine any potential risks associated with gaps between the rails and the mattress of the bed. Also assess size of resident in proportion to siderail openings..."</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 323	<p>Continued From page 207</p> <p>a. Medical record review for Resident #6 documented an admission date of 5/15/2000 with diagnoses of Paralysis Agitans, Hypertension, Adult Failure to Thrive, Osteoarthritis, Osteoporosis, Percutaneous Endoscopy Gastrostomy, History of Cerebrovascular Accident, Depressive Disorder, Neurogenic Bladder, and Osteopenia.</p> <p>Observations in Resident #6's room on 9/11/12 at 3:24 PM, revealed Resident #6 lying in bed with full side rails up on both sides of the bed. The resident is very small and thin, eyes open, no speech, actively moving around in bed. The side rails measured 5 1/4 inches from top rail to middle and 5 1/2 inches from middle rail to the bed frame. The mattress does not fit the bed, leaving a 3 inch gap between mattress and siderail and a 6 inch space between the mattress and the footboard. This resident could freely move around in the bed and was at risk for entrapment between the top and middle rail and between the middle rail and the bottom rail.</p> <p>b. Medical record review for Resident #13 documented an admission date of 11/21/09 with diagnoses of Mental Retardation, Seizure Disorder, Depression, Anemia, Heart Failure, and Diabetes Mellitus. Review of the quarterly minimum data set (MDS) dated 7/5/12 documented in Section C for Cognitive Patterns, Resident #13's Brief Interview for Mental Status (BIMS) score was "7" indicating severe impairment in decision making. The MDS documented the resident's height was 62 inches and weight was 121 pounds.</p>	F 323			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
(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 323	<p>Continued From page 208</p> <p>Observations of the side rails on Resident #13's bed revealed the space from the middle rail to bottom rail was 5 1/2". The space from the mattress to the rail on both sides of the bed measured 5 1/2". A wedge was placed between the mattress and the siderail in the middle section of the bed on the resident's right side. This resident could freely move around in the bed and was at risk for entrapment between the middle rail and the bottom rail.</p> <p>Observations in room 405 on 9/14/12 at 11:10 AM, revealed Resident #13 lying in the bed with side rails up on both sides of the bed.</p> <p>During an interview in the administrative hall on 9/20/12 at 10:10 AM, Nurse #4 was asked what was the facility's policy for assessing and reassessing the use of side rails. Nurse #4 stated, "On admission and then I believe it is supposed to be done quarterly. I'm not really sure. I'll see if we have a policy."</p> <p>c. Medical record record for Resident #84 documented an admission date of 2/13/12 with diagnoses of Dementia, Anxiety, Depression, Hypertension, and Anemia. Review of the quarterly MDS dated 7/12/12 documented in Section C for Cognitive Patterns, Resident #84 was coded a "2" indicating moderately impaired and poor decision making. The MDS documented the resident's height was 62 inches and weight was 79 pounds.</p> <p>Observations of the siderails on Resident #84's bed on 9/18/12 at 11:05 AM, revealed the space from the top rail to the middle rail was 5 1/4" and the middle rail to the bottom rail was 5 1/2". This</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 323	<p>Continued From page 209</p> <p>resident could freely move around in the bed and was at risk for entrapment between the top rail and the middle rail and between the middle rail and the bottom rail.</p> <p>During an interview on 1st McRee hallway on 9/18/12 at 11:05 AM, certified nursing assistant (CNA) #13 was asked if Resident #84 attempts to get out of the bed on her own. CNA #13 stated, "Yes, she has before. She tries to get out of the bed at the end of the rail. I have to straighten her up in bed and move her from the rail. She will move over to the side of the bed."</p> <p>d. Medical record review for Resident #122 documented an admission date of 9/1/11 with diagnoses of Schizophrenia, Traumatic Brain Injury, Hypertension, and renal Insufficiency. Review of the annual MDS dated 8/9/12 documented in Section C for Cognitive Patterns, Resident #122's BIMS score was "3" indicating severe impairment in decision making. The MDS documented the resident's height was 62 inches and the weight was 121 pounds.</p> <p>Observations in Resident #122's room on 9/17/12 at 3:23 PM, revealed the resident lying in bed with the head of bed up and 3/4 side rails up on both sides of bed. The resident was confused and moving about in bed. The siderails on Resident #122's bed space from the middle rail to bottom rail was 5 1/2". This resident could freely move around in the bed and was at risk for entrapment between the middle rail and the bottom rail.</p> <p>During an interview in Resident #122's room on 9/17/12 at 3:23 PM, CNA #3 was asked if the resident moved around in the bed. CNA #3</p>	F 323			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 323	<p>Continued From page 210</p> <p>stated, "Yes ma'am. He moves around a lot, all over the bed. Sometimes he gets his legs off the sides of the bed."</p> <p>The facility failed to ensure a safe environment by utilization of side rails with spaces greater than the recommended 4 3/4" dimension resulting in an entrapment risk which placed these fours residents in IJ.</p> <p>B. FALLS</p> <p>1. Medical record review for Resident #23 documented an admission date of 1/29/99 with diagnoses of Subarachnoid Hemorrhage, Hemiplegia, Diabetes, Dementia, Hypertension and Seizure Disorder and a readmission date of 9/10/12 with a new diagnosis of Dilantin Toxicity.</p> <p>Review of an incident report revealed the following: a. 8/31/12 - "...resident noted to have fallen in hallway out of w/c [wheelchair] onto floor..." b. 9/3/12 - "...resident found on floor in room... resident stated he fell while getting out of w/c because he felt weak... Abrasion noted to R [right] side of lip..." c. 9/4/12 - "...resident found on floor in an upright position... in dayroom bathroom... he stated "I was getting off commode trying to sit in wheelchair and lost my balance... c/o [complained of] headache... swollen red area noted on R side of face... treatment: Emergency Dept. [Department]..." d. 9/5/12 - "...Resident was found outside of building... laying flat on back with a swollen lip and abrasions to R side of face, knee and shoulder... treatment: Emergency Dept..."</p> <p>Review of nurses notes documented the</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 323	<p>Continued From page 211</p> <p>following: a. 9/10/12 at 11:30 AM - "...Received back to facility from [named hospital]..." 9/10/12 at 5:30 PM - "...Resident found on floor in activities bathroom..."</p> <p>Review of care plan dated 5/1/12 had no updates with new interventions documented following the falls that occurred on 8/31/12, 9/3/12, 9/4/12, 9/5/12, or 9/10/12 after the hospital return.</p> <p>The Director of Nursing and Minimum Data Set nurse were not available for interview during the last four days of the survey. There was no one at the facility to interview to provide confirmation of the falls.</p> <p>The facility's failure to adequately assess the resident and implement new interventions after each of the five falls placed Resident #23 in IJ.</p> <p>C. ENVIRONMENT ACCIDENT HAZARDS</p> <p>1. Building Layout The facility is divided into 3 buildings: Magoffin, McRee, and Cleveland.</p> <p>Magoffin has three floors:</p> <ul style="list-style-type: none"> a. 1st Magoffin houses residents. b. 2nd Magoffin houses residents. c. 3rd Magoffin was closed with no residents residing on the unit. This area was dark with no lighting available; the walls had visible open areas to the outside; with the presence of trash, cigarette butts and roaches located in several areas of this unit. An open emergency cart (crash cart) was present that contained needles, syringes and intravenous fluids that was accessible to anyone that entered this floor. 	F 323			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 323	<p>Continued From page 212</p> <p>McRee had two floors:</p> <ul style="list-style-type: none"> a. 1st McRee houses residents. b. 2nd McRee was closed with no residents residing in this area, however residents have to enter this area to access the residents' bank and the Social Worker's office located on the 2nd Cleveland unit. This unit was dark with electricity turned off in the fuse box. There was trash and insects located in this area. <p>Cleveland has two floors:</p> <ul style="list-style-type: none"> a. 1st is where the Administrative offices are with no residents housed in this area. b. 2nd Cleveland has no residents housed but contains the residents' bank and the Social Worker's office which the residents have access at all times. c. 2nd Magoffin and 2nd Cleveland are connected via the 2nd McRee unit that is closed with no residents or staff housed here. <p>There is an elevator in the middle of the Magoffin building that has capability of going to the basement and 3rd Magoffin.</p> <p>During an interview in the conference room on 9/12/12 at 4:47 PM, the Financial Services Manager (FSM) was asked if the residents used the closed 2nd McRee floor. The FSM stated, "...They [residents] take the elevator [1st Magoffin to 2nd Magoffin through the fire doors to 2nd McRee] and follow the hall around [to 2nd Cleveland where the resident personal funds office/business office and the social worker's office are located]. It winds and turns to the business office... A lot come on their own if they are alert. The majority come on there own. Sometimes I have to help them open the door.</p>	F 323			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 323	<p>Continued From page 213</p> <p>Some do wander down [to the closed 2nd McRee living area and into 2nd Cleveland]. An extremely tall white man came down one day last week. He didn't know where he was... She [Resident #19] comes up to visit, to sing, to use the bathroom... The lights are off and the doors are closed. The FSM was asked if after staff left for the day if the 2nd floor through 2nd McRee and into 2nd Cleveland would be dark. The FSM stated, "Yes ma'am. After the social worker leaves the lights are out. It would be completely dark..." The FSM was asked, if it was after hours and a resident came up through 2nd McRee to 2nd Cleveland, would anyone know or be there. The FSM stated, "No ma'am. No one would be there."</p> <p>Observations and interview on 2nd McRee on 9/12/12 at 12:00 PM, revealed Resident #19 (who was coded as moderately impaired with poor decision making, required cues and supervision according to her most recent cognitive assessment) alone on the closed dark area of 2nd McRee. Resident #19 was asked how she came to be in room 508 on 2nd McRee. Resident #19 stated, "I came up here to pee. I not scared..." Resident #19 was asked by the surveyor how she got up there. Resident #19 stated, "I'll show you." Resident #19 proceeded to lead the surveyors through the dark hallway of 2nd McRee (a closed unit) that lead through the open fire doors to 2nd Magoffin, to the elevator and down to her room on 1st Magoffin. The Social Worker's office and the business office/bank are located on the dark closed unit of 2nd McRee where residents have to go to obtain their money.</p> <p>Observations of 2nd McRee (closed unit) on</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 323	<p>Continued From page 214</p> <p>9/12/12 revealed the following:</p> <p>a. 5:35 PM, the light switches did not turn the lights on.</p> <p>b. 5:40 PM, in room 508 in the top drawer of the bedside table, 4 disposable razors, a smoking pipe with a tobacco like substance in it, and dead roaches too numerous to count were found.</p> <p>c. 5:45 PM, the exit door, at the end of the hall near room 507, opened to a metal set of stairs that led to the ground. The exit door could be pushed open. There was a key pad on the wall beside the door that was not functional. The surveyor was able to step down to the metal stairs, allow the door to close and re-enter the building without the door locking or an alarm sounding.</p> <p>d. 5:47 PM, the exit door near room 501 led to an emergency stairwell. There were 2 key pads on the wall beside the door that were not functional. The surveyor was able to go outside, but not able to re-enter the building, until another surveyor opened the door.</p> <p>e. 5:50 PM, the exit door near room 514 opened to the outside of the building and made a "chirp" sound.</p> <p>f. 5:54, PM the exit door near room 518 opened to the outside. The surveyor was able to go outside, allow the door to close, and re-enter the building without the door locking or an alarm sounding. There was a key pad on the wall that was not functional.</p> <p>g. 5:57 PM, survey team left 2nd McRee. The staff had not responded to the "chirp" sound.</p> <p>Observations of 3rd Magoffin (closed unit) on 9/12/12 revealed the following:</p> <p>a. 6:00 PM, room 317 the window was open and had no screen. A cigarette butt was laying on the</p>	F 323			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 323	<p>Continued From page 215</p> <p>floor.</p> <p>b. 6:01 PM, room 316 there was an open space on the exterior wall where the air unit had been removed that left the space open to the outside.</p> <p>c. 6:02 PM, room 320 a cigarette butt was in the sink.</p> <p>d. 6:03 PM, room 325 a cigarette butt was laying on the floor.</p> <p>e. 6:04 PM, the clean linen room had 2 cigarette butts on the floor.</p> <p>f. 6:05 PM, the nurses station had an open space in the exterior wall where the air unit had been removed that left the space open to the outside.</p> <p>g. 6:05 PM, near the nurses station there was an unlocked emergency crash cart that contained needles and syringes, 3 bags of intravenous fluids and 8 needles attached to syringes.</p> <p>h. 6:05 PM, the elevator came to 3rd Magoffin with a resident, the receptionist, a certified nursing assistant and the Vice President.</p> <p>i. 6:10 PM, the surveyor rode the elevator down to the 1st floor, back up to 3rd floor and down again. The 3rd floor was accessible to anyone who got on the elevator and pushed the 3rd floor elevator button.</p> <p>During an interview in the hall of 1st Magoffin on 9/12/12 at 3:40 PM, the Assistant Activity Director (AAD) was asked if Resident #19 goes to the other floor. The AAD stated, "I've never seen her go up to the other floor, unless she is going to the bank to get a quarter. She does that every day." The AAD was asked if the bank was located in the part of the building that is closed. The AAD stated, "Yes, through the double doors down the blue carpet and around."</p> <p>During an interview in the conference room on</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 323	<p>Continued From page 216</p> <p>9/13/12 at 10:30 AM, the Vice President (VP) was asked on what date the 2nd Floor of McRee had been closed to residents. The VP stated the 2nd McRee unit was closed and the last resident was moved out on the evening shift of 7/27/12.</p> <p>The facility failed to ensure the environment was free from accident hazards when 33 of 97 ambulatory residents could come and go unsupervised from their unit and enter through 4 of 4 doors to have access to 2nd McRee (a closed unit) and enter through 2 of 3 doors to 3rd Magoffin that allowed access to stairways and an elevator to enter the closed dark units of 2nd McRee and 3rd Magoffin. The ability of residents to enter unoccupied areas of the building that are not staffed and have access to the outside, via elevators, stairs and doors could lead to elopement in a high crime area, with access to a major highway less than (<) 500 yards from the facility and a functioning railroad yard with multiple train tracks < than 200 yards from the facility; falls with no ability to call for help and the capability of anyone entering the building through non secured doors placed all the 97 residents at risk for immediate jeopardy.</p> <p>2. Observations of non-functioning smoke detectors in rooms as followed:</p> <p>a. Resident #82's room on 9/10/12 at 11:15 AM, smoke detector beeping.</p> <p>b. Resident #14's room on 9/10/12 at 5:20 PM and 9/11/12 at 8:45 AM, smoke detector beeping.</p> <p>c. Resident #60's room on 9/10/12 at 10:40 AM and 6:00 PM, on 9/11/12 at 8:55 AM and on 9/12/12 at 3:20 PM, smoke detector beeping.</p> <p>d. Resident #70's room on 9/12/12 at 10:45 AM, smoke detector beeping.</p>	F 323			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 325 SS=G	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record review and interview, it was determined the facility failed to ensure that 2 of 31 (Residents #101 and 124) sampled residents of the 38 included in the stage 2 review received nutritional management to assess and develop approaches to maintain the resident's nutritional status. The failure to provide nutritional intervention for residents with unplanned significant weight loss resulted in actual harm to Residents #101 and 124.</p> <p>The findings included:</p> <p>1. Medical Record review for Resident #101 documented an admission date of 4/1/10 with diagnoses of Diabetes Mellitus, Subarachnoid Hemorrhage, Hemiplegia Left-sided Weakness, Convulsions, Cerebrovascular Accident, Schizophrenia, Hypotension, Status Post Pneumonia and Dysphagia. Review of the weight tracking record dated 9/14/11 documented the</p>	F 325			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 325	<p>Continued From page 218</p> <p>resident's weight was 195 lbs. Six months later on 3/24/12 the resident's weight was documented as 175 lbs. The loss of 20 lbs in 6 months is an unplanned significant weight loss of 10.26 percent (%). Review of the dietary notes did not document a dietary assessment or progress note from 9/20/11 until 4/15/12. A Nutritional Risk Assessment was completed on 4/15/12 by the registered dietician (RD). The nurses notes, physician's orders and physician progress notes from 9/20/11 to 4/15/12 did not address the unplanned 10.26% weight loss. There is no documentation that the physician was notified of the unplanned significant (10.26%) weight loss. There were no interventions put in place to prevent further unplanned weight loss until 4/15/2, when the RD had assessed the resident.</p> <p>2. Medical record review for Resident #124 documented an admission date of 3/23/12 with diagnoses of Atrial Fibrillation, Diabetes Mellitus, Bradycardia, Hypertension, Dementia, Agitation, Sexual Inappropriate Behavior, Alcohol Abuse, Muscle Weakness, Symbolic Dysfunction and Dysphagia Oropharyngeal Phase. Review of the weight tracking record dated 3/24/12 documented an admission weight of 200 lbs and 4/20/12 documented a weight of 190 lbs. The unplanned weight loss of 10 lbs in one month (5%) was a significant weight loss. Review of the Nutrition Risk Assessment dated 4/1/12 documented that Resident #124 was moderate risk for weight loss. Resident #124's weight was documented as 182 lbs on 5/9/12, by this time the weight loss had reached 9% before his weight was addressed by the physician. The registered dietician nor the certified dietary manager (CDM) had addressed the resident's unplanned weight loss as of</p>	F 325			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 325	<p>Continued From page 219 9/20/12 when the survey was completed. The nurses notes do not address the unplanned significant weight loss.</p> <p>3. During an interview in the Director of Nursing's (DON) office on 9/13/12 at 8:30 AM, the DON was asked if the facility had a registered dietitian. The DON stated, "...don't have one, we did have a contract one but she hasn't been here since March [2012]..."</p> <p>During an interview in the conference room on 9/17/12 at 3:30 PM, the Vice President (VP) was asked, "When is the last time you actually had an RD?" The VP stated, "April 30th [2012]." The VP was asked "Is there a reason you have not hired another [RD] to take her place?" The VP stated, "No reason in particular." The VP was asked, "If you have resident's with dietary needs, what do you do?" The VP stated, "That you will have to ask [named CDM]." The CDM was unavailable for interview due to being out on family medical leave since 9/9/12.</p> <p>During an interview conference room on 9/18/12 at 8:42 AM, Nurse #4 was asked who addresses the dietary concerns when the CDM is not available. Nurse #4 stated, "We reply on the Doctor, since there is no RD."</p> <p>There was no one at the facility to interview to provide confirmation of the unplanned significant weight loss.</p> <p>The facility failed to provide nutritional intervention for residents with unplanned significant weight loss which resulted in actual harm to Residents #101 and 124.</p>	F 325			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>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 received proper treatment for respiratory care by not administering oxygen (O2) at the rate prescribed by the physician and failed to ensure the nasal cannula was no on the floor for 2 of 2 (Residents #82 and 118) sampled residents receiving oxygen therapy of the 38 residents included in the stage 2 review.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Review of the facility's "Oxygen Therapy" policy documented, "...A physician's order is required and shall include liter flow rate and administration device... Set the oxygen delivery rate according to the physician's orders..." Medical record review for Resident #82 documented an admission date of 1/5/11 with 	F 328			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 328	<p>Continued From page 221</p> <p>diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus Type I, Hypertension, Chronic Renal Disease, Bipolar Disorder, Hypothyroidism, Gout, Obesity, and Defiant Behavior. Review of the annual Minimum Data Set (MDS) dated 12/30/11 and the quarterly MDS dated 6/14/12 documented in section O that Resident #82 received oxygen therapy.</p> <p>Review of the care plan dated 6/20/12 documented, "...Resident has SOB [shortness of breath] / respiratory problems... Administer oxygen at 2/L [liters] via nasal cannula..."</p> <p>Review of a physician's order dated 8/1/12 documented, "...O2 @ [at] 2L/MIN [liters per minute] BNC [binasal cannula]..."</p> <p>Observations in Resident #82's room on 9/10/12 11:15 AM, revealed Resident #82 sleeping with the head of the bed slightly elevated and receiving O2 at 6 L/MIN via concentrator.</p> <p>Observations and an interview in Resident #82's room on 9/18/12 at 8:30 AM, revealed Resident #82 lying in bed, receiving O2 at 6 L/MIN via concentrator. Nurse #1 checked the O2 rate on the concentrator and stated, "It's on 5 [L/MIN] or 6. I'll have to check and see what it should be on. I don't know." Nurse #1 returned to room at 8:36 AM, and stated, "I checked the orders and your oxygen is supposed to be on 2 [L/MIN]."</p> <p>Observations in Resident #82's room on 9/19/12 at 7:20 AM, revealed Resident #82 was lying in bed. The oxygen concentrator was on 2 L/MIN with the nasal cannula laying on the floor.</p>	F 328			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 328	<p>Continued From page 222</p> <p>During an interview in Resident #82's room on 9/19/12 at 9:30 AM, Certified Nursing Assistant (CNA) #13 was asked where should the oxygen tubing be placed when not in use. CNA #13 stated, "Not on the floor."</p> <p>3. Medical record review for Resident #118 documented an admission date of 6/29/11 with diagnoses of Chronic Obstructive Pulmonary Disease, Right Lower Lobe Pneumonia, Anemia, Diabetes Mellitus, Hypotension, Depression, Dementia, Hypomagnesemia and Urinary Tract Infection. Review of a physician's orders dated 8/30/12 documented, "...O2 at 2l/m bnc [binasal cannula]..." Review of the care plan dated 9/5/12 documented, "...Administer oxygen at 2 L [liters] via BNC. Observe oxygen precautions..."</p> <p>Observations in Resident #118's room on 9/10/12 at 10:45 AM, revealed Resident #118 lying in bed receiving O2 at 6 L/MIN via concentrator.</p> <p>Observations in Resident #118's room on 9/14/12 at 3:00 PM, revealed Resident #118 lying in bed, receiving a breathing treatment via nebulizer and O2 at 6 L/MIN BNC via concentrator.</p> <p>Observations in Resident #118's room on 9/17/12 at 9:00 AM and 11:00 AM and on 9/19/12 at 8:45 AM, revealed Resident #118 lying in bed receiving O2 at 4 L/MIN BNC via concentrator.</p> <p>During an interview in Resident #118's room on 9/19/12 at 8:50 AM, Nurse #4 was asked what was the oxygen rate. Nurse #4 stated, "...It [O2] is set between 3 [L/M] and 4... it should be set on 2..."</p>	F 328			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on pharmacy review, medical record review, observation and interview, it was determined the facility failed to ensure residents were free from unnecessary medication as evidenced by not having a diagnosis for the use of Lovenox and not evaluating a resident for abnormal movement or monitor for side effects associated with antipsychotic drug therapy for 2</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 329	<p>Continued From page 224 of 38 (Residents #23 and 43) sampled residents included in the stage 2 review.</p> <p>The findings included:</p> <p>1. Medical record review for Resident #23 documented an admission date of 1/29/99 with diagnoses of Subarachnoid Hemorrhage, Hemiplegia, Diabetes, Dementia, Hypertension and Seizure Disorder and a readmission date of 9/10/12 with a new diagnosis of Dilantin Toxicity. Review of physician's orders dated 9/10/12 documented, "...Enoxaparin [Lovenox] 40 mg [milligrams] inject @ [at] 1200 [12:00 PM] daily..." Resident #23 was receiving Lovenox daily since the hospital return on 9/10/12. The facility had no documentation for the need of the use of Lovenox medication.</p> <p>Observations in Resident #23's room on 9/14/12 at 11:56 AM, Nurse #6 administered Lovenox 40 mg subcutaneous (SQ) as ordered.</p> <p>During an interview in the administrative office on 9/14/12 at 11:00 AM, the Medical Director was asked why Resident #23 was prescribed Lovenox. The Medical Director stated, "...I am not really sure... that is an order from the hospital... it seems like they [hospital] just put everyone on Lovenox to prevent blood clots... I don't know how long they want him to continue on Lovenox..."</p> <p>2. Medical record review for Resident #43 documented an admission date 12/22/09 with diagnoses of Vascular Dementia with Delusions, Diabetes Mellitus, Hypertension, Alcohol Abuse, Convulsions, Cerebrovascular Accident, and Left Hemiparesis. Review of the physician's orders</p>	F 329			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118	
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F 329	Continued From page 225 dated 6/6/12 documented, "...SEROQUEL 25 MG TAB [tablet]... TAKE 1 TABLET BY MOUTH AT BEDTIME..." Review of care plan dated 11/29/11 and updated 8/7/12 documented, "...POTENTIAL FOR COMPLICATIONS RELATED TO USE OF PSYCHOTROPIC MEDICATIONS... 2. ASSESS/MONITOR/RECORD ADVERSE SIDE EFFECTS..." Review of "Summary of All Recommendations / Findings" from the Consulting pharmacist dated 6/13/12 documented, "...Please obtain an abnormal movement evaluation and place in the chart to monitor for side effects associated with antipsychotic drug therapy. This evaluation is recommended every 6 mos [months]... Last assessment 11/14 [2011]..." During an interview in the conference room on 9/18/12 at 8:55 AM, Nurse #4 was asked if a more current abnormal movement evaluation had been completed. Nurse #4, made no response.	F 329		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE 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 4 of 6 (Nurses #2, 6, 7 and 9) nurses administered medications with a	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 332	<p>Continued From page 226</p> <p>medication error rate of less than 5 percent (%). Nine medication errors were made out of 58 opportunities for error, which resulted in a medication error rate of 15.517%.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Review of the facility's "Medication Administration Policy" documented, "...Prior to administration, the medication and dosage schedule on the resident's MAR [medication administration record] is compared with the medication label... Medications are administered in accordance with written orders of the attending physician... Medications are administered within (60 minutes) of scheduled time... routine medications are administered according to the established medication administration schedule for the facility... If a dose of regularly scheduled medication is... given at other than the scheduled time... the space provided on the front of the MAR for that dosage administration is initialed and circled... An explanatory note is entered on the reverse side of the record..." Medical record review for Resident #116 documented an admission date of 9/8/11 with diagnoses of Dementia, Psychosis, Depression, Coronary Artery Disease, Osteoarthritis, Aggressive Behavior and Diabetes Mellitus. Review of a physician's order dated 9/8/12 documented, "...D/C [discontinue] Celexa..." <p>Observations in Resident #116's room on 9/12/12 at 9:42 AM, Nurse #2 administered Citaloprim (Celexa) 10 mg by mouth with Resident #116's other medications. The administration of the Celexa resulted in medication error #1.</p>	F 332			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 332	<p>Continued From page 227</p> <p>3. Medical record review for Resident #58 documented an admission date of 2/14/12 with diagnoses of Congestive Heart Failure, Seizure Disorder, Hypertension and Aneurysm. Review of physician's orders dated 7/1/12 documented, "...Multivitamin tablet take 1 tablet by mouth daily..."</p> <p>Observations in Resident #58's room on 9/12/12 at 9:16 AM, Nurse #6 administered one tablet of multivitamin with iron to Resident #58, instead of the plain multivitamin as ordered. The administration of multivitamin with iron resulted in medication error #2.</p> <p>During an interview on 1st Magoffin on 9/12/12 at 9:30 AM, Nurse #6 was asked about the difference between the plain multivitamin and the multivitamin with iron. Nurse #6 stated, "...we always give her the multivitamin with iron..."</p> <p>During an interview on 1st Magoffin on 9/12/12 at 10:30 AM, Nurse #2 was asked about multivitamins. Nurse #2 stated, "...we only use the multivitamin with iron if the doctor orders it specifically..."</p> <p>4. Medical record review for Resident #86 documented an admission date of 10/27/08 with diagnoses of Diabetes Mellitus, Gout, Hypertension and Esophageal Reflux. Review of physician's orders dated 7/27/12 documented, "...Hydralazine 25 mg [milligrams]... ½ tab [tablet] take 1 tablet by mouth every 8 hours..."</p> <p>Observations in Resident #86's room on 9/12/12 at 8:44 AM, Nurse #7 administered a whole tablet</p>	F 332			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 332	<p>Continued From page 228</p> <p>of Hydralazine 25 mg instead of the ½ tablet of Hydralazine 12.5 mg which was ordered. The administration of Hydralazine 25 mg resulted in medication error #3.</p> <p>During an interview on 1st McRee on 9/12/12 at 9:00 AM, Nurse #7 was asked about the correct dosage of the Hydralazine. Nurse #7 stated, "...I thought the pharmacy had packaged the ½ tablets..."</p> <p>5. Medical record review for Resident #53 documented an admission date of 11/18/11 with diagnoses of Diabetes Mellitus, Hypertension and Paranoid Schizophrenia. Review of physician's orders dated 8/1/12 documented, "...Glimepiride 2 mg tablet take 1 tablet by mouth 2 times daily with meals [scheduled at 7:15 AM and 5:15 PM]... Benztropine 1 mg tablet take 1 tablet by mouth 2 times daily... Haloperidol 15 mg by mouth 2 times daily... Apresoline 25 mg tablet take 1 tablet by mouth 3 times daily... Lisinopril 20 mg tablet take 1 tablet by mouth 2 times daily..." Review of a physician's order dated 8/21/12 documented, "...Begin Metformin 500 mg 1 BID [twice daily 9:00 AM and 5:00 PM]..."</p> <p>Observations in Resident #53's room on 9/17/12 at 11:10 AM, revealed Nurse #9 administered Glimepiride 2 mg by mouth at 11:10 AM instead of at the scheduled time of 7:15 AM, with breakfast. Nurse #9 administered Benztropine, Haloperidol, Apresoline, Lisinopril, Metformin and Losartan at 11:10 AM instead of at the scheduled time of 9:00 AM. Nurse #9 then documented the medications on the Medication Administration Record (MAR) as having been given at 9:00 AM. This resulted in medication errors #4, 5, 6, 7, 8</p>	F 332			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
(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 332	Continued From page 229 and 9. During an interview on 1st Magoffin on 9/17/12 at 12:00, Nurse #9 was asked about the medications being given late. Nurse #9 stated, "...Today is my first day to work here... I was hired this weekend to work 11-7, but this morning [named Vice-President] called me to come in on day shift because they had nobody to work... I will be faster tomorrow... "	F 332			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. 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 2 of 10 (Nurses #7 and 9) did not make significant medication errors for 2 of 10 (Residents #53 and 86) sampled residents observed receiving medications. The findings included: 1. Review of the facility's "Medication Administration Policy" documented, "...Medications are administered in accordance	F 333			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 333	<p>Continued From page 230</p> <p>with written orders of the attending physician... If (two consecutive doses) of vital medication are withheld or refused, the physician is notified..."</p> <p>2. Medical record review for Resident #53 documented an admission date of 11/18/11 with diagnoses of Diabetes Mellitus, Hypertension and Paranoid Schizophrenia. There were 2 significant medication errors as follows:</p> <p>a. Review of a physician's order dated 8/21/12 documented, "...Begin Metformin 500 mg [milligrams] 1 BID [twice daily]..." Review of nurse's notes on the physician order sheet dated 8/29/12 documented, "...called and refaxed 8/29/12..." Review of nurse's notes on the physician's order sheet dated 9/7/12 documented, "...refaxed 9/7/12 s/w [spoke with] [office nurse] re: [regarding] Metformin..." Review of the August 2012 Medication Administration Record (MAR) had no Metformin documented as being given during the month, totaling 20 missed doses. Review of the September 2012 MAR had no Metformin documented as being given on a routine BID basis until 9/8/12. Resident #53 had a delay of 17 days between the Metformin order and the actual doses given.</p> <p>b. Review of physician's orders dated 8/1/12 documented, "...Glimepiride 2 mg tablet take 1 tablet by mouth 2 times daily with meals..."</p> <p>Observations during medication administration on 9/17/12 at 11:10 AM, Nurse #9 administered Glimepiride 2 mg by mouth at 11:10 AM, instead of at the scheduled time of 7:15 AM (with breakfast).</p>	F 333			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 333	Continued From page 231 During an interview on 1st Magoffin on 9/17/12 at 12:00 PM Nurse #9 was asked about the medications being given late. Nurse #9 stated, "...Today is my first day to work here... I was hired this weekend to work 11-7, but this morning [named Vice-President] called me to come in on day shift because they had nobody to work... I will be faster tomorrow..." 3. Medical record review for Resident #86 documented an admission date of 10/27/08 with diagnoses of Diabetes Mellitus, Esophageal Reflux, Gout and Hypertension. Review of physician's orders dated 7/27/12 documented, "...Hydralazine 25 mg... ½ tab take 1 tablet by mouth every 8 hours..." Observations during medication administration on 9/12/12 at 8:44 AM, Nurse #7 administered a whole tablet of Hydralazine 25 mg instead of the ½ tablet of Hydralazine 12.5 mg which was ordered. This resulted in a significant medication error. During an interview on 1st McRee on 9/12/12 at 9:00 AM, Nurse #7 was asked about the correct dosage of the Hydralazine. Nurse #7 stated, "...I thought the pharmacy had packaged the ½ tablets..." 4. During an interview in the Director of Nursing's (DON) office on 9/14/12 at 12:15 PM, the DON was asked about medication errors. The DON stated, "...medication errors are not reported to me... most of the time I find them when I am checking the MARs..."	F 333			
F 353 SS=L	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS	F 353			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 353	Continued From page 232 The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on policy review, review of a payroll payout form, review of a time slip, review of nursing agency invoices, contract review, review of a job description, pharmacy review, review of nursing schedules, observations, and interviews, it was determined the facility failed to ensure there was sufficient and competent nursing staff on 3 of 3 (1st McRee, 1st Magoffin and 2nd Magoffin units) nursing units to ensure residents were provided with the necessary care and services to meet their highest level of well-being. The facility failed to maintain dignity and respect	F 353			

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

PRINTED: 10/08/2012
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OMB NO. 0938-0391

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F 353	<p>Continued From page 233</p> <p>for a resident when staff knowingly left a resident wet with urine during the evening and night shift, which resulted in the resident developing two new avoidable in house acquired stage II pressure ulcers causing actual harm to Resident #82. The facility failed to ensure adequate and competent nursing staff as evidenced by 4 of 6 (Nurses #2, 6, 7 and 9) nurses observed administering medications had a medication error rate 15.517 percent (%); ensure expired medications were not available for use and having incorrect narcotic counts in 3 of 8 (1st McRee medication cart, 1st Magoffin West medication cart and 1st Magoffin medication room) medication storage areas. The facility failed to ensure adequate and competent nursing staff assessed, identified, and provided treatments for pressure ulcers for Residents #54, 60, 74, and 82. The failure of the facility to maintain an adequate and competent nursing staff resulted in IJ for all residents residing in the facility. The facility failed to recognize abuse; protect residents from verbal, mental and physical harm; failed to follow the facility's abuse policy for reporting and investigating abuse which placed Residents #14, 47, 68, 81, 82 and 116 in IJ. The facility failed to ensure there was sufficient nursing staff which placed all of the 97 residents residing in the facility in IJ. The Administrator, Facility Consultant, Vice President and the Nursing Supervisor were informed of this IJ on 9/20/12 at 6:00 PM. This IJ was considered present and ongoing at the time of exit.</p> <p>The findings included.</p> <p>1. Review of the August 2012 licensed nursing schedule documented, 1 full-time Registered Nurse (RN) and 2 part-time RNs. There was no</p>	F 353			

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

PRINTED: 10/08/2012
FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 353	<p>Continued From page 234 RN coverage on 8/5/12.</p> <p>Review of the August 2012 nurses schedule for Licensed Practical Nurses (LPN) documented the following:</p> <ul style="list-style-type: none"> a. 1st McRee 7-3 shift had no nurse coverage for 8/6, 8/13, 8/14, 8/15, 8/16, 8/20, 8/21 and 8/30/12. b. 1st McRee 3-11 shift had no nurse coverage for 8/4, 8/5, 8/8, 8/13, 8/18, 8/19 and 8/22/12. c. 1st McRee 11-7 shift had no nurse coverage for 8/18/12. d. 1st Magoffin 7-3 shift had no nurse coverage for 8/5, 8/18, 8/19 and 8/27/12. e. 1st Magoffin 3-11 shift had no nurse coverage for 8/3, 8/6, 8/17, 8/20, 8/25, 8/26 and 8/31/12. f. 2nd Magoffin 7-3 shift had no nurse coverage for 8/13, 8/21, and 8/22/12. g. 2nd Magoffin 3-11 shift had no nurse coverage for 8/2, 8/7, 8/11, 8/12, 8/16, 8/18, and 8/27/12. h. 2nd Magoffin 11-7 shift had no nurse coverage for 8/20/12. <p>Review of the September 2012 licensed nursing schedule documented the following:</p> <ul style="list-style-type: none"> a. 1st McRee 7-3 shift had no nurse coverage for 9/8/12, 9/9/12, 9/22/12, and 9/23/12. b. 1st McRee 3-11 shift had no nurse coverage for 9/1/12, 9/2/12, 9/10/12, 9/15/12, 9/16/12, 9/29/12 and 9/30/12. c. 1st Magoffin 7-3 shift had no nurse coverage for 9/8/12 and 9/9/12. d. 1st Magoffin 11-7 shift had no nurse coverage for 9/8/12, 9/9/12, 9/22/12, 9/23/12 and 9/24/12. <p>The September 2012 nursing schedule documented no RN coverage for the facility on 9/1/12, 9/2/12, 9/8/12, 9/9/12, 9/15/12, 9/16/12,</p>	F 353			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 353	<p>Continued From page 235 9/22/12 and 9/23/12.</p> <p>Review of the "Payroll Hours Paid Out" for August 25, 2012 through September 20, 2012 documented a total of 86.39 hours for the Registered Nurse coverage for the 4 week period. The required coverage hours was this period of time 240 hours.</p> <p>The facility could not produce invoices to show RN or LPN coverage on the dates noted above for August or September 2012.</p> <p>Review of the nursing agency time slips given to the survey team by the Vice President on 9/14/12 documenting agency presence in the facility in August 2012 could not be verified by correlating payment invoices. The payroll invoices presented have the appearance of being altered.</p> <p>During an interview in the Financial Services Manager's (FSM) office on 9/14/12 at 11:30 AM, the FSM provided copies of nursing agency invoices and confirmed the last payment for an agency nurse was 5/20/12.</p> <p>Observations in the administrative hall beside the Director of Nursing's (DON) office on 9/14/12 at 4:00 PM, Nurse #6 was standing in the hall beside the DON's office attempting to give the Vice President the narcotic keys from 1st Magoffin as she was trying to leave the facility.</p> <p>Observations on 1st Magoffin on 9/14/12 at 4:05 PM, revealed no licensed nursing staff available on the unit.</p> <p>Observations on 2nd Magoffin on 9/14/12 at 4:10</p>	F 353			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 353	<p>Continued From page 236</p> <p>PM, revealed no licensed nursing staff available on the unit.</p> <p>During a phone interview in the conference room on 9/12/12 at 8:50 AM, a family member for Resident #6 stated, "She [Resident #6] was dirty, not cared for, had holes in her garments, was soiled, the sheets were threadbare. I could not find a nurse at first, she eventually came around but did not know anything about the patient... How can she [nurse] effectively care for patient's if she doesn't know their history?"</p> <p>During an interview in the conference room on 9/12/12 at 11:35 AM, the Vice President was asked about the RN and LPN coverage not being documented on the September schedule. The Vice President stated, "I didn't write it down, it is all up here [pointing to her head.]"</p> <p>During an interview in the conference room on 9/13/12 at 11:30 AM, Nurse #10 stated, "...There is no RN on the weekends..."</p> <p>During an interview in the conference room on 9/13/12 at 5:30 PM, the Administrator was asked about RN coverage. The Administrator stated, "To be honest I thought we had weekend RN coverage but [Named Vice President] is over that."</p> <p>During an interview in the administrative hall on 9/14/12 at 4:00 PM, Nurse #6 (nurse for 1st Magoffin unit) was asked about nurse coverage for her unit. Nurse #6 stated, "...I am trying to give them [keys] to someone and they won't take them..." Nurse #6 was then asked if she had someone to relieve her. Nurse #6 stated, "No</p>	F 353			

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F 353	<p>Continued From page 237</p> <p>ma'am..." Nurse #6 was then asked if she had been working today and who was scheduled to relieve her on the unit. Nurse #6 stated, "Yes... I don't know..."</p> <p>During an interview on the 2nd Magoffin hallway on 9/14/12 at 4:10 PM, Nurse #2 and Nurse #6 were asked, "Who is here to work the 3 to 11 shift? Nurse #6 stated, "...Just one... [named Nurse #17] on 1st McRee... He won't take the keys either..." Nurse #2 stated, "He [Nurse #17] won't take the keys..." He is the only licensed nurse here to work the 3 to 11 shift for the entire building when Nurse #2 and Nurse #6 left.</p> <p>During an interview in the 1st Magoffin hall on 9/14/12 at 4:20 PM, Nurse #4 was asked who was scheduled to work the 3-11 shift as relief for the day shift nurses. Nurse #4 confirmed she doesn't know who is working the 3-11 shift. Nurse #4 stated, "...I can't take all these sets of keys and be responsible for 3 different areas... you need to ask [named the Vice President]..."</p> <p>During an interview at the 1st Magoffin nurses' station on 9/14/12 at 4:25 PM, Nurse #6 was asked if she had seen a Registered Nurse working the weekends. Nurse #6 stated, "No RN on the weekends... I haven't seen an RN working on the weekends since the wound nurse left..."</p> <p>During an interview on 1st Magoffin on 9/17/12 at 12:00, Nurse #9 was asked about the medications being given late. Nurse #9 stated, "...Today is my first day to work here... I was hired this weekend to work 11-7, but this morning [named Vice-President] called me to come in on day shift because they had nobody to work... I will</p>	F 353			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 353	<p>Continued From page 238 be faster tomorrow... "</p> <p>During an interview in the conference room on 9/17/12 at 4:28 PM, the Vice President stated, "I've been doing staffing over 30 years. I use to be a certified nursing assistant (CNA), I was taught to go by census for staffing. No, we do not have a staffing grid. The census is 96 in house, there may be another lay off."</p> <p>2. The facility failed to ensure there was adequate and competent staff to maintain dignity and respect for a resident when staff knowingly left a resident wet with urine during the evening and night shift, which resulted in actual harm when Resident #82 developed two new avoidable in house acquired stage II pressure ulcers. Refer to F241.</p> <p>3. The facility failed to ensure Nurses 2, 6, 7 and 9 administered medications with a medication error rate of less than 5 percent (%). Nine medication errors were made out of 58 opportunities for error, which resulted in a medication error rate of 15.517%. Refer to F332.</p> <p>4. The facility failed to ensure expired medications were not available for use and narcotic counts were reconciled for the 1st McRee medication cart, 1st Magoffin West medication cart and 1st Magoffin medication room. Refer to F431.</p> <p>5. The facility failed to ensure adequate and competent nursing staff assessed/accurately assessed or provided treatments for pressure ulcers as ordered for Residents #54, 74, and 82 which resulted in an IJ when residents developed</p>	F 353			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 353	Continued From page 239 avoidable in-house acquired pressure ulcers or pressure ulcers deteriorated. Refer to F314.	F 353			
F 354 SS=L	6. The facility's failed to recognize abuse; protect residents from verbal, mental and physical harm; failed to follow the facility's abuse policy for reporting, investigating and timely suspending the accused perpetrator. Refer to F223, F224, F225 and F226. 483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on review of time slip, review nursing schedules and interview, it was determined the facility failed to ensure there was a Registered Nurse (RN) that worked at least 8 consecutive hours a day, 7 days a week. The facility failed to have a RN at least 8 consecutive hours a day, 7 days a week which placed all of the 97 residents residing in the facility in immediate jeopardy (IJ). The Administrator, Facility Consultant, Vice	F 354			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 354	<p>Continued From page 240</p> <p>President and the Nursing Supervisor were informed of this IJ on 9/20/12 at 6:00 PM. This IJ was considered present and ongoing at the time of exit.</p> <p>The findings included:</p> <p>Review of the time slip for Nurse #15 (RN) documented the following: "DATE WORKED: 8/10/12 TIME STARTED 0700... TIME FINISHED: 1330... REGULAR HOURS: 6.50..."</p> <p>During an interview with in the conference room on 9/14/12 at 1:20 PM, the Director of Nursing (DON) was asked about RN coverage for the weekends. The DON stated, "I can't answer that for sure [Named Vice President] she handles that [referring to staffing and RN coverage]."</p> <p>During an interview in the conference room on 9/14/12 at 1:20 PM, the Vice-President was asked about RN coverage. The Vice-President stated, "We do have a weekend RN I will get the schedule..." The Vice-President was unable to provide documentation of weekend RN coverage for every weekend.</p> <p>Review of the September 2012 nursing schedule revealed there was no RN scheduled to work on the following dates: 9/1/12, 9/2/12, 9/8/12, 9/9/12, 9/15/12, 9/16/12, 9/22/12 and 9/23/12.</p> <p>During an interview in the conference room on 9/12/12 at 11:35 AM, the Vice President was asked about the RN coverage not documented on the September schedule. The Vice President stated, "I didn't write it down, it is all up here [pointing to her head]."</p>	F 354			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 356 SS=D	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to post nurse staffing information on a daily basis at the beginning of</p>	F 356			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 356	Continued From page 242 each shift on 3 of 9 (9/12/12, 9/17/12 and 9/18/12) days of the survey. The findings included: 1. Observations in the administrative hall on 9/12/12 at 1:00 PM, revealed the nurse staffing was posted for all three shifts, not just the day shift as required. 2. Observations in the administrative hall on 9/17/12 at 9:30 AM, revealed no posted daily staffing. During an interview in the administrative hall on 9/17/12 at 10:30 AM, the Vice President (VP) was asked why the staffing was not posted for the day shift on 9/17/12. The VP stated, "...It [nurse staffing] is posted on 1st Magoffin... I just forgot to post it around here..." 3. Observations in the administrative hall on 9/18/12 at 3:30 PM, revealed there was no nurse staffing posted.	F 356			
F 361 SS=G	483.35(a) QUALIFIED DIETITIAN - DIRECTOR OF FOOD SVCS The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis. If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian. A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic	F 361			

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

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OMB NO. 0938-0391

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F 361	<p>Continued From page 243</p> <p>Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, contract review, medical record review and interview, it was determined the facility failed to employ a Registered Dietitian (RD) and ensure an RD assessed and implemented interventions that addressed nutritionally compromised residents with unplanned significant weight loss which resulted in actual harm for 2 of 38 (Residents #101 and 124) sampled residents included in the stage 2 review.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Review of the facility's resident rights policy documented, "...Resident... rights to adequate and proper treatment and care established by any applicable statute, rule, regulation, or contract..." <p>During an interview in the conference room on 9/13/12 at 10:26 AM, the Vice President (VP) stated, "She [certified dietary manager (CDM) is on FMLA [family medical leave of absence] since 9/9/12." The VP was asked, "Is there a Registered Dietitian (RD) to over see while the CDM is gone. The VP stated, "No."</p> <p>During an interview in the conference room on 9/17/12 at 3:30 PM, the VP was asked, "When is the last time you actually had an RD?" The VP stated, "April 30th [2012]." The VP was asked "Is</p>	F 361			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 361	Continued From page 244 there a reason you have not hired another [RD] to take her place?" The VP stated, "No reason in particular." The VP was asked, "If you have resident's with dietary needs, what do you do?" The VP stated, "That you will have to ask [named CDM]." The CDM was unavailable for interview due to being out on family medical leave as of 9/9/12. 2. Review of the "Professional Services Contract" dated 12/1/11 for Contractor [named dietitian] documented, "...TERMS OF CONTRACT - The term of this Contact [Contract] shall be from December 1, 2011 through June 30, 2012..." During an interview in the Director of Nursing's (DON) office on 9/13/12 at 8:30 AM, the DON was asked if the facility had a registered dietitian. The DON stated, "...don't have one, we did have a contract one but she hasn't been here since March [2012]..." There was no one at the facility to interview to provide confirmation of the unplanned significant weight loss. The facility failed to provide nutritional intervention for residents with unplanned significant weight loss which resulted in actual harm to Residents #101 and 124.	F 361			
F 362 SS=D	483.35(b) SUFFICIENT DIETARY SUPPORT PERSONNEL The facility must employ sufficient support personnel competent to carry out the functions of the dietary service.	F 362			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 362	Continued From page 245 This REQUIREMENT is not met as evidenced by: Based on interview, it was determined the facility failed to honor food preferences for 1 of 5 (Resident #60) sampled residents of the 16 interviewable residents included in the stage 1 review. The findings included: During an interview in Resident #60's room on 9/10/12 at 10:00 AM, 9/12/12 at 10:30 AM, 9/13/12 at 4:00 PM, 9/18/12 at 11:00 AM and 9/19/12 at 8:30 AM, Resident #60 voiced concerns of the meat he receives for breakfast each morning. Resident #60 stated, he gets sausage that is too hard to chew and when they bring him something else instead it is usually not what he wants. During an interview at the receptionist desk on 9/19/12 at 9:10 AM, the Patient Advocate was asked what is a resident to do if they are unhappy with their meals or food received. The Patient Advocate stated, "They [residents] tell me and I write it up and give it to [named the Director of Nursing (DON)] for review... and [named DON] gives it to [named the certified dietary manager]..." What if [the DON] is not here? The Patient Advocate stated, "Then I give it too [named the Administrator]..." There was no one available to interview to confirm or get information in regard to choices.	F 362			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371			

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F 371	Continued From page 246 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure foods were served under sanitary conditions as evidenced by uncovered food items on meal trays and gnats and flies flying in the hallway during 2 of 2 (Supper on 9/10/12 and lunch on 9/14/12) dining observations. The findings included: 1. Review of the facility's "DAILY PRACTICE TIPS TO PREVENT THE "UP SLIP" ON GERMS" documented, "...18. FOOD COVERED DURING TRANSPORTATION ON UNITS..." 2. Observations on 2nd Magoffin on 9/10/12 at 5:30 PM, revealed the fruit on the trays was uncovered and Certified Nursing Assistants (CNA) #6, 7, and 8) were walking from one end of the hall with the meal trays to the other end of the hall. Gnats and flies were observed on the hallway. 3. Observations on 2nd Magoffin on 9/14/12 at	F 371			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 371	Continued From page 247 12:25 PM, revealed the slaw, fruit and cake on the trays were uncovered. The door to the cart was left open and CNA #4 and 5 were walking long distances with the food uncovered with gnats and flies on the hallway. 4. The facility was unable to provide documentation of inservices given to CNAs in regard to serving meals. During an interview in the conference room on 9/13/12 at 10:02 AM, the Director of Nursing was asked about inservices for the CNAs. The Director of Nursing stated, "No inservices done [for CNAs] the last three years..."	F 371		
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure that garbage and refuse was disposed of properly for 2 of 9 (9/10/12 and 9/13/12) days of the survey. The findings included: 1. Review of the facility's non infectious waste policy documented, "...Dumpsters are emptied and taken to the landfill (6) days a week..." 2. Observations of the two dumpsters, outside the facility, during the initial tour, on 9/10/12 at	F 372		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 372	Continued From page 248 10:15 AM, revealed bags of garbage were overflowing the top of the dumpsters, lids not closed and garbage was on the ground around the dumpsters. There were approximately 10 to 5 bulging bags of garbage on the ground around the dumpsters. 3. Observations of the two dumpsters, outside the facility, on 9/13/12 at 10:00 AM, revealed bags of garbage were overflowing the top of the dumpsters, lids not closed and garbage and refuse was on the ground around the dumpsters. There were approximately 10 bulging bags of garbage on the ground around the dumpsters with a foul smelling odor noted. 4. During an interview in the front hallway on 9/18/12 at 11:25 AM, the Maintenance Supervisor was asked how often the dumpsters were emptied and do they usually get over full. The Maintenance Supervisor stated, "...they usually come every 6 to 7 days... they don't usually get over full except when we have storms... put in a lot of stuff..."	F 372			
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.	F 406			

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F 406	Continued From page 249 This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and interview, it was determined the facility failed to provide specialized rehabilitation services for 3 of 4 (Residents #101, 104, and 124) sampled residents receiving therapy services of the 38 resident s included in the stage 2 review. The findings included: 1. Review of the facility's "POLICY FOR PT [physical therapy] /OT [occupational therapy] /ST [speech therapy]" policy documented, "Once an order is obtained for PT/OT/ST from the doctor you will call [number listed] and notify [named Vice President] you have a new order for one of the following services. She will then notify the therapist of the new order for therapy." 2. Medical Record review for Resident #101 documented an admission date of 4/1/10 and a readmission date of 4/2/12 with diagnoses of Diabetes Mellitus, Subarachnoid Hemorrhage, Convulsions, Hypotension, Cerebrovascular Accident, Status Post Pneumonia, Schizophrenia, Hemiplegia Left-sided Weakness, and Dysphagia. Review of a physician's orders dated 4/5/12 documented, "...ST to Tx [treat] 5x [times] wk x 60 days... OT 5x/wk x 8 wks..." The facility was unable to provide documentation that the physician had discontinued ST or OT. Review of the Minimum Data Set (MDS) dated 4/9/12 documented that the resident started ST and OT on 4/5/12. The MDS dated 6/1/12 documented the resident had received both ST and OT for 360 minutes in the last 7 days and documented the	F 406			

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F 406	<p>Continued From page 250</p> <p>start date for ST and OT as 5/26/12. There was not a therapy end date documented in the 6/1/12 MDS. The facility was unable to provide documentation of the ST and OT visits beyond the date of 4/25/12.</p> <p>During an interview in the conference room on 9/20/12 at 11:15 AM the Vice President (VP) was asked if the facility could provide further documentation of ST or OT visits for Resident #101. The VP stated, "That's it."</p> <p>3. Medical record review for Resident #104 documented an admission date of 8/2/11 with diagnoses of Schizophrenia, Dementia, Diabetes Mellitus, Seizure Disorder and Tardive Dyskinesia and a readmission date of 5/16/12 with new diagnoses of Subdural Hematoma and Percutaneous Endoscopy Gastrostomy Tube. Review of a physician's order dated 6/4/12 documented, "...ST & [and] OT to evaluate and treat as indicated..." A physician's clarification order dated 6/4/12 documented, "...OT clarification order: OT to provide there. [therapeutic] ex [exercises], there act [activities], and positioning at 5x/wkx 8 wks... ST clarification order- ST to tx 5x weekly x 60 days for [writing illegible] dysphagia... [writing illegible]... receptive... [writing illegible]..."</p> <p>Review of the care plan dated 6/4/12 documented, "...OT for therapy act and positioning... Perform therapy 5xwk x8wks... ST for oral dysphagia and oral therapy... provide therapy 5xweek x 60 days..."</p> <p>Review of the Minimum Data Set (MDS) dated 6/8/12 documented 250 minutes of Speech</p>	F 406			

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F 406	<p>Continued From page 251</p> <p>Therapy during the past 7 days with therapy start date of 6/4/12. Review of the MDS dated 6/8/12 documented 250 minutes of Occupational Therapy during the past 7 days with therapy start date of 6/4/12. Review of the MDS dated 6/14/12 documented 250 minutes of Speech Therapy during the past 7 days and 250 minutes of Occupational Therapy during the past 7 days. Review of the MDS dated 6/29/12 documented Speech Therapy end date of 6/15/12 and Occupational Therapy end date of 6/15/12. The facility was unable to provide any documentation that Speech Therapy was ever provided. The facility was unable to provide any documentation that OT was provided after 6/10/12.</p> <p>During an interview in the reception office on 9/20/12 at 8:30 AM, the receptionist was asked what the process for obtaining speech and occupational therapy was. The receptionist stated, "...the nurses notify [the Vice President] and she contacts the therapists... if there is a problem with insurance, then I make arrangements for the resident to go out for therapy..." The receptionist was asked if Resident #104 had gone out for therapy. The receptionist stated, "No."</p> <p>During an interview in the medical records office on 9/20/12 at 8:40 AM, the medical records director was asked if there were any records of OT or ST for Resident #104. The medical records director stated, "No."</p> <p>During an interview in the administration hallway on 9/20/12 at 8:45 AM, the Vice President was asked if there were any records of OT or ST being contacted. The Vice President stated, "No."</p>	F 406			

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

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F 406	<p>Continued From page 252</p> <p>During an interview in the conference room on 9/20/12 at 11:00 AM, the Vice President presented a faxed copy of an OT evaluation dated 6/4/12, which was unsigned by the physician, and a faxed copy of an OT Therapy Daily/Weekly Progress Report which covered the period of 6/4/12 to 6/10/12. The Vice President was asked about Speech Therapy notes. The Vice President shrugged. The Vice President was asked about the second week of OT notes. The Vice President stated, "...I don't know..."</p> <p>4. Medical record review for Resident #124 documented an admission date of 3/23/12 with diagnoses of Atrial Fibrillation, Diabetic Mellitus, Bradycardia, Hypertension, Dementia, Agitation, Sexual Inappropriate Behavior, Alcohol Abuse, Muscle Weakness, Symbolic Dysfunction and Dysphagia Oropharyngeal Phase. Review of a physician's orders dated 3/28/12 documented, "...ST to Tx 5x weekly x 60 days... OT...5x/wk x 8 wks..." Review of a physician's order dated 6/1/12 documented, "...D/C [discontinue] from skilled OT intervention after tx as of 5/14/12... ST to D/C Tx... 5/15/12..." Review of the MDS dated 4/2/12 documented OT and ST start dates of 3/28/12. Review of the MDS dated 6/21/12 documented the resident had received both ST and OT for 360 minutes in the last 7 days with a start date of 3/28/12. There was not a therapy end date documented in the 6/21/12 MDS. The facility was unable to provide documentation of ST and OT visits beyond the date of 4/20/12.</p> <p>During an interview in the conference room on 9/20/12 at 11:15 AM the Vice President (VP) was asked if the facility could provide further</p>	F 406			

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

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F 406	Continued From page 253 documentation of ST or OT visits for Resident #124. The VP stated, "That's it."	F 406			
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. 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 obtain needed dental services for 1 of 1 (Resident #63) sampled resident for the 38 residents included in the stage 2 review. The findings included: Review of the facility's "DENTAL... SERVICES" policy documented, "...OBJECTIVE: In an effort to provide optimal quality of care to each resident. Diagnostic testing will be provided to maintain optimal function and timely treatment. PROCEDURE: 1. Obtain written order from MD [medical doctor] for needed services. 2. Send referral to assigned staff to set up appointment. (a) Dental referral to Social Services...3. Notify Social Services for financial approval...If the resident has no payment source to cover	F 412			

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

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F 412	<p>Continued From page 254</p> <p>treatment, Social Worker to call family and see if payment for services can be arranged. If no payment source found, the facility will pay for services..."</p> <p>Medical record review for Resident #63 documented an admission date of 12/3/08 with diagnoses of Diabetes Mellitus, Schizophrenia, Dementia and Dyslipidemia. Review of the minimum data set (MDS) with an assessment reference date (ARD) of 10/31/11 section L was coded for D and F indicating obvious or likely cavity or broken natural teeth and mouth or facial pain, discomfort or difficulty with chewing. Review of the care area assessment (CAA) review report dated 10/19/11 section Dental Care Summary Notes documented, "RESIDENT WITH CARIES AND DECAYED TEETH SOME WITH BLACK SEGMENTS AT GUM LINE. RESIDENT WITH COMPLAINTS OF TOOTHACHE DURING ASSESSMENT PERIOD AND WAS PLACED ON ANTIBIOTIC THERAPY. WILL PROCEED WITH WITH CARE PLANNING TO REFER TO DENTIST FOR EVALUATION AND TREATMENT AS INDICATED GIVE ANTIBIOTIC AS ORDERED AND TO MEDICATE FOR PAIN AS NEEDED FOR TOOTHACHE..."</p> <p>Observation in the dayroom on 9/10/12 at 10:30 AM, Resident #63 was was noted to have two top teeth visible with brownish stains, bottom teeth chipped and broken with brownish stains noted and need of cleaning.</p> <p>Observations in the dayroom on 9/10/12 at 3:00 PM and 4:45 PM and 9/12/12 at 8:00 AM, Resident #63's teeth needed cleaning.</p>	F 412			

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

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F 412	<p>Continued From page 255</p> <p>During an interview in the Social Worker's (SW) office on 9/12/12 at 3:38 PM, the SW was asked about dental assistance for Resident #63. The SW stated, "I call [named dental office] and they put them [residents] on a list. If they are... eligible then the state will cover it otherwise family responsible party have to pay for it. [Named dental office] will call family and let them know cost of examination." The SW proceeded to place a call to the dental office to find out when Resident #63 was last seen by the dentist. Resident #63 was last seen by the dentist in 2007, which was prior to admission to the facility. The SW further stated, "She's [referring to Resident #63] is not... eligible so her daughter would have to pay for it and she don't like to spend money." The surveyor then asked the SW about other sources to assist with dental needs of the resident. The SW stated, "I don't have any other sources..."</p> <p>During an interview in the conference room on 9/12/12 at 4:00 PM, the Director of Nursing (DON) was asked who was responsible for dental appointments for residents. The DON stated, "Whoever did the CAA should have told nurse on unit so they could notify Social Services and she will in turn check with [named dental provider] to see if they can see her if not then we would check for our services to see who can see her."</p> <p>During an interview in the administration office on 9/12/12 at 4:20 PM, Nurse #3 was asked about a dental consult for Resident #63. Nurse #3 stated, "I put it [dental consult] on the CAA. When we have the care plan meeting, I normally if SW in there will tell her then. If not in care plan meeting will call her [SW] and let her know."</p>	F 412			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 412	Continued From page 256 During an interview on the administration hall on 9/13/12 at 5:50 PM, the SW stated, "She doesn't have [financial resources] so her daughter will have to pay for any dental service and I know her she doesn't like to spend any money." During an interview in the conference room on 9/14/12 at 1:15 PM, the DON was asked about dental appointments for residents. The DON stated, "[Named Social Worker] makes the appointment she checks to see if they have... If not... eligible and family can't pay then the facility has to take care of it..."	F 412			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431			

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

PRINTED: 10/08/2012
FORM APPROVED
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F 431	<p>Continued From page 257</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, review of med-pass - medications with shortened expiration dates provided by the consultant pharmacist, observation, and interview, it was determined the facility failed to ensure medications were not stored past their expiration date and/or stored in a locked compartments in 3 of 8 (1st McRee medication cart, 1st Magoffin west hall medication cart and 1st Magoffin medication room) medication storage areas and Nurse #11 failed to ensure controlled medications were reconciled accurately.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Observations on 1st McRee medication cart on 9/19/12 at 1:15 PM revealed 11 capsules of Temazepam 15 milligrams (mg) with expiration date of 9/8/12. <p>During an interview at the 1st McRee medication cart on 9/19/12 at 1:15 PM, Nurse #13 was asked to read the expiration date on the Temazepam.</p>	F 431			

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

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F 431	<p>Continued From page 258</p> <p>Nurse #13 stated, "...expired 9/8/12..."</p> <p>Observations in 1st McRee hallway on 9/12/12 at 8:16 AM, revealed the 1st McRee medication cart was unlocked and unattended. Nurse #7 was asked if the medication cart was locked when she left the cart and went into the hydro room. Nurse #7 stated, "No ma'am, it wasn't locked."</p> <p>2. Observations on 1st Magoffin west hall medication cart on 9/19/12 at 1:35 PM, revealed one Lorazepam 0.5 mg with an expiration date of 8/23/12.</p> <p>During an interview at the 1st Magoffin west hall medication cart on 9/19/12 at 1:35 PM, Nurse #2 was asked to read the expiration date on the Lorazepam 0.5 mg card. Nurse #2 stated, "...expired 8/23/12..."</p> <p>3. Review of the "2005 American Society of Consultant Pharmacists and MED-PASS... MEDICATIONS WITH SHORTENED EXPIRATION DATES" documented, "...Humulin R [regular] Insulin regular injection... Vials: Expire 28 days after opening... Novolin R Regular human insulin injection... Vial: Expires 42 days after opening..."</p> <p>Observations in the 1st Magoffin medication room on 9/19/12 at 1:45 PM, revealed a vial of Novolin R insulin with an open date of 7/3/12, a vial of Humulin R insulin with an open date of 7/24/12 and a vial of Humulin R insulin with an open date of 8/20/12.</p> <p>During an interview in 1st Magoffin medication room on 9/19/12 at 1:45 PM, Nurse #2 was asked</p>	F 431			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 431	<p>Continued From page 259</p> <p>to read the open dates on the insulin vials. Nurse #2 stated, "...[Novolin R insulin] opened 7/3/13, [Humulin R] opened 7/24/12, [Humulin R] opened 8/20/12..." Nurse #2 was asked how long is insulin used after it is opened. Nurse #2 stated, "...I think until it is used up..."</p> <p>4. Review of the facility's "CONTROLLED MEDICATIONS" policy documented, "...6. Shift to shift nurse will count and visually identify all controlled medications and note quantities of individual medications and note total number of cards and sheets. 7. The on-coming nurse will sign with the off-going nurse at the same time count is completed..."</p> <p>Review of a controlled substance record for Tramadol 50 mg tablets on the 1st Magoffin medication cart on 9/13/12 at 3:30 PM, documented that 12 tablets remain on the cart.</p> <p>Observations in the medication room on 1st Magoffin on 9/13/12 at 3:31 PM, revealed 11 Tramadol 50 mg tablets in the locked controlled substance box on the east medication cart.</p> <p>During an interview in the 1st Magoffin medication room on 9/13/12 at 3:35 PM, Nurse #11 was asked if she had counted narcotics with another nurse when she came into work. Nurse #11 stated, "...counted with [named a nurse] on east but didn't catch Tramadol... "</p> <p>During an interview in the 1st McRee hallway on 9/18/12 at 4:00 PM, Nurse #11 stated, "...I have to get this off of my chest. It's been bothering me all week. I didn't count with anyone that day you checked the cart..."</p>	F 431			

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F 441 SS=F	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(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 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>	F 441			

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F 441	Continued From page 261 This REQUIREMENT is not met as evidenced by: Based on policy review, observation, and interview, it was determined the facility failed to ensure proper infection control practices were followed to prevent the potential spread of infections as evidenced by 2 of 6 (Nurses #2 and 8) nurses failed to practice the proper use of gloves and hand hygiene during medication administration; Nurse #6 placed cigarettes in her own mouth, lit the cigarettes, and then passed them to residents; a syringe was left uncovered and a dirty urinal sitting on the bedside table beside a water pitcher and a cup of water; spills left on the floor; a uncovered scoop left on top of an ice machine; dirty items placed on the clean linen cart; air conditioner duct that was leaking water beside a table with clean folded linen; and gnats flying in and around the ice machine on 5 of 9 (9/10/12, 9/11/12, 9/12/12, 9/13/12, and 9/17/12) days of the survey. The facility failed to maintain an infection control program to provide a safe and sanitary environment to help prevent the development and transmission of disease and infection for all the 97 residents residing in the facility. The findings included: 1. Review of the facility's "Daily Practice Tips" documented, "...WASH HANDS AFTER TOUCHING BLOOD, BODY FLUIDS, SECRETIONS, AND CONTAMINATED... WEAR GLOVES WHEN TOUCHING BLOOD, BODY FLUIDS, SECRETIONS, AND CONTAMINATED ITEMS..."	F 441			

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F 441	<p>Continued From page 262</p> <p>Observations in room 411 on 9/11/12 at 9:16 AM, revealed Nurse #2 put on a pair of gloves, removed an Exelon medication patch from Resident #127's upper back and applied a new patch. Nurse #2 removed the gloves, patted Resident #127 on the shoulder and returned to the medication cart in the hallway. Nurse #2 did not wash her hands after removing the gloves.</p> <p>2. Review of the facility's "Enteral Tube Medication Administration" policy documented, "...To assure the safe and effective administration of medications per enteral feeding tube by a licensed nurse... Equipment: 1. Gloves... "</p> <p>Observations in Resident #104's room on 9/13/12 at 8:20 AM, revealed Nurse #8 checked the Percutaneous Endoscopy Gastrostomy (PEG) tube placement, administered medications and flushes, then reconnected PEG tube to the enteral feeding pump. Nurse #8 did not wear gloves.</p> <p>During an interview on 1st Magoffin hall on 9/13/12 at 8:40 AM, Nurse #8 stated, "I know what I did was wrong. I didn't wear gloves."</p> <p>During an interview in the Director of Nursing's office (DON) on 9/14/12 at 1:00 PM, the DON asked what she expected when nurses were working with PEG tubes. The DON stated, "I would expect that gloves are worn when working with PEG."</p> <p>3. Observations in the courtyard on 9/11/12 at 1:50 PM, revealed Nurse #6 placed cigarettes in her own mouth, lit the cigarettes, and then passed them to individual residents to smoke.</p>	F 441			

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F 441	<p>Continued From page 263</p> <p>Nurse #6 repeated the lighting of the cigarettes for three residents.</p> <p>4. Observations in room 411 on 9/10/12 at 9:55 AM and on 9/11/12 at 9:30 AM, revealed a syringe not covered or bagged and a dirty urinal sitting on the bedside table beside a water pitcher and a cup of water.</p> <p>During an interview in room 411 on 9/11/12 at 10:30 AM, Nurse #2 was asked if acceptable for the urinal, uncovered syringe and water pitcher to be on the same table. Nurse #2 stated, "No, the syringe should be in a bag..."</p> <p>5. Review of the facility's "Daily Practice Tips" documented, "...CLEAN UP ALL SPILLS IMMEDIATELY..."</p> <p>Observations in room 411 on 9/10/12 at 10:00 AM, revealed a large wet area on the floor beside the head of the bed. Certified nursing assistant (CNA) #3 was asked what was the wet area. CNA #3 stated, "...probably urine..." CNA #3 left the room without cleaning the wet area from the floor.</p> <p>6. Observations during the initial tour on 2nd Magoffin on 9/10/12 beginning at 10:00 AM, revealed an uncovered scoop on top of the ice machine laying on a plastic bag.</p> <p>7. Observations in room 401 on 9/12/12 at 8:35 AM, revealed an open gallon container (top missing) of shampoo/body wash setting on the floor at the bedside. CNA #3 entered the room and stated, "I have the cap to that bottle." CNA #3 picked up the container of shampoo/body wash from the floor and placed it in the clean linen cart.</p>	F 441			

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

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F 441	Continued From page 264 During an interview at the 1st McRee nurses' station on 9/19/12 at 3:40 PM, Nurse #4 was asked if she would expect a CNA to take a gallon bottle of shampoo/body wash from room to room for resident bathing and then place in a clean linen cart. Nurse #4 stated, "No, not the big bottle. No!" Observations in the hallway on 1st McRee on 9/12/12 at 8:45 AM, CNA #3 picked up a roll of trash bags from the floor and placed them on top of the clean linen in the clean linen cart. CNA #3 then used the clean linen for residents. During an interview in the hallway of 1st McRee on 9/12/12 at 8:45 AM, CNA #3 was asked what she picked up from the floor. CNA #3 stated, "My bags... I shouldn't do that." The surveyor asked why she should not do that. CNA #3 stated, "Because you are not supposed to. It causes cross-contamination..." 8. Observations in the laundry room on 9/12/12 at 9:35 AM and on 9/14/12 at 9:00 AM, revealed three 5 gallon buckets placed on the floor under the ceiling air conditioner duct that was leaking water beside a table with clean folded linen. One of the buckets was 3/4 full of water. During an interview in the laundry room on 9/14/12 at 9:05 AM, the laundry supervisor was asked if the leak had been reported. The laundry supervisor stated, "Yes... I told [named maintenance supervisor]. I think it was last week. He just hasn't gotten to me yet..." 9. Observations in the ice machine room on 1st	F 441			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 441	Continued From page 265 Magoffin on 9/17/12 at 10:20 AM and 12:00 PM, revealed the sliding door on the ice machine was open. Ice was present in the bin and gnats were flying in the room. 10. Review of the facility's "Infection Control Log" revealed the facility had no documentation of monitoring infections from August 2008 until January 2012. There was no monitoring documented for April 2012 or June 2012. There was no systematic collection, analysis, or trending of the data to identify infections and infection risks. During an interview at the 1st McRee nurses' station on 9/19/12 at 4:30 PM, Nurse #4 was asked if the facility had an infection control program. Nurse #4 stated, "I just picked that up about 2 1/2 to 3 weeks ago. [The Director of Nursing] was doing that. I don't really know anything about it [infection control program]..." During an interview in the conference room on 9/19/12 at 4:40 PM, the Vice President (VP) was asked if there was tracking and trending data for infection control. The VP did not respond.	F 441			
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure air	F 456			

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

PRINTED: 10/08/2012
FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 456	<p>Continued From page 266</p> <p>conditioner units were in operating condition in 11 of 68 (Rooms #110, 124, 201, 206, 208, 214, 216, 217, 219, 221, and 412) resident rooms and the 1st Magoffin activity room.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Observations in room 110 on 9/10/12 at 10:00 AM, revealed the air conditioner was leaking water and there was a moldy substance on the air conditioner. The air conditioner was not working. 2. Observations in room 124 on 9/11/12 at 9:50 AM, revealed there was not a functioning air conditioner unit in the resident's room. 3. Observations during the initial tour of on 9/10/12 beginning at 10:00 AM, revealed the following: <ol style="list-style-type: none"> a. Room 201 - air conditioner unit was not functional. b. Room 206 - air conditioner unit was not functional. c. Room 208 - air conditioner unit was not functional. d. Room 214 - air conditioner unit was not functional. e. Room 216 - air conditioner unit was not functional. f. Room 217 - air conditioner unit was not functional. g. Room 219 - air conditioner unit was not functional. h. Room 221 - air conditioner unit was not functional. i. Room 412 air conditioner unit was not functional. 	F 456			

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

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F 456	Continued From page 267 During an interview on 2nd Magoffin hall on 9/11/12 at 2:45 PM, the Maintenance Supervisor confirmed that he did have air conditioner units that were broken and not functional. 4. Observation in the 1st Magoffin activity room on 9/17/12 at 4:00 PM and on 9/18/12 at 3:30 PM, revealed a wet blanket on the floor under the air conditioner unit. During an interview in the 1st Magoffin activity room on 9/18/12 at 3:30 PM, the Maintenance Supervisor stated, "...the blankets are wet and happen when someone turns the heat on after the air has been on and the air unit sweats..."	F 456			
F 460 SS=E	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure each bedroom was equipped to assure full visual privacy for each resident residing in 13 of 68 (Rooms 108, 120, 201, 203, 208, 210, 211, 216, 217, 219, 411, 414 and 416) resident rooms. The findings included:	F 460			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 460	Continued From page 268 1. Observations on 1st Magoffin on 9/10/12 beginning at 11:00 AM revealed the following: a. Room 108-bed 1 had no privacy curtain between the door and bed. Room 108- bed 3 had no privacy curtain. b. Room 120-2 had no privacy curtain at the foot of the bed or in between bed and window. 2. Observations on 2nd Magoffin on 9/10/12 beginning at 10:00 AM, revealed the following: a. Room 201-1 had no privacy curtain to provide full visual privacy for the resident. b. Room 203-1 had no privacy curtain to provide full visual privacy for the resident. c. Room 208-2 had no privacy curtain to provide full visual privacy for the resident. d. Room 210 had no privacy curtain to provide full visual privacy from the doorway. e. Room 211 had no privacy curtain to provide full visual privacy for the resident. f. Room 216 had no privacy curtain between the two beds to provide full visual privacy for the residents. g. Room 217 had no privacy curtain to provide full visual privacy for the resident in bed two. h. Room 219 had no privacy curtain to provide full visual privacy for the resident in bed two. 3. Observations during the initial tour of 1st McRee on 9/10/12 beginning at 10:00 AM revealed the following: a. Room 411-4 beds had no privacy curtain between the hallway door and the residents' bed. b. Room 414 the privacy curtain would not pulled around the foot of the bed. c. Room 416 had no privacy curtain between bed 1 and 2. The privacy curtain was too short to go	F 460			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 460	Continued From page 269 between beds 2 and 3 and had missing hangers. 4. During an interview on 1st McRee on 9/19/12 at 10:35 AM, Certified Nursing Assistant (CNA) #2, was asked what she does to ensure privacy for her residents during bathing or care. CNA #2 stated, "I pull the privacy curtain around them..." CNA #2 was asked what do you do if the curtain is too short or missing? CNA #2 stated, "I will move the bed around..."	F 460			
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on review of a fire security service ticket, policy review, observation and interview, it was determined the facility failed to ensure there was a functional call light system in 6 of 68 (Rooms #216, 217, 221, 401, 420 and 424) resident rooms and the 1st Magoffin bathroom located just past the double doors and the 1st Magoffin bathroom across from room 105. The findings included: 1. Review of a Fire and Security Service Ticket dated 6/19/12 documented, "...Problem - Complaint / Work to be Performed STAFF unplugging and vandalizing master phones for nurse call system... Work Performed Tamperproof masterphones by installing Boxes	F 463			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 463	<p>Continued From page 270 and straps to Existing countertops..."</p> <p>2. Review of the facility's call signal policy documented, "Policy: A properly functioning call signal device will be provided for each resident... Purpose: The call light is a signal to indicate the need to respond to resident's request for assistance..."</p> <p>3. Observations in room 216 on 9/10/12 at 9:00 AM and on 9/17/12 at 9:50 AM, revealed call light system was not functioning.</p> <p>Observations and interview on 2nd Magoffin on 9/17/12 at 5:00 PM, revealed call light not functioning in rooms 216. The maintenance supervisor verified the call light was not functioning.</p> <p>4. Observations in room 217 on 9/17/12 at 9:50 AM, revealed the call light system was not functioning.</p> <p>Observations and interview on 2nd Magoffin on 9/17/12 at 5:00 PM, revealed call light not functioning in rooms 217. The maintenance supervisor verified the call light was not functioning.</p> <p>5. Observations in room 221 on 9/10/12 at 9:00 AM, revealed call light system was not functioning.</p> <p>Observations and interview on 2nd Magoffin on 9/17/12 at 5:00 PM, revealed call light not functioning in rooms 221. The maintenance supervisor verified the call light was not functioning.</p>	F 463			

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F 463	Continued From page 271 6. Observations in room 401 on 9/13/12 at 9:35 AM, revealed the call light hung over the headboard, touching the floor. During an interview in room 401 on 9/14/12 at 11:45 AM, the Director of Nursing picked up the call light and stated, "It's broke. It won't work. Somebody should have reported that and got her [Resident #82] a bell." 7. Observations in room 420 on 9/14/12 at 8:51 AM, revealed call light was not working, the end of the cord is broken. 8. Observations on 1st McRee on 9/12/12 at 5:15 PM, and on 9/18/12 at 8:50 AM, revealed the call lights in room 424 for beds #2 and 3 were not functioning properly. There was no signal alarm at the nurses station. Certified Nursing Assistant #14 confirmed the call lights were not functioning. 9. Observations on 1st Magoffin on 9/10/12 beginning at 9:45 AM, revealed an unlocked bathroom located just past the double doors without a call light system. Observations on 1st Magoffin on 9/11/12 at 9:45 AM, revealed an unlocked bathroom across from room 105 without a call light system. This bathroom was accessible to residents. 10. During an interview in the Administrator's office on 9/17/12 at 9:47 AM, the Administrator was asked if he was aware of any problems with the call light system not functioning properly. The Adm stated, "Yes, we had the company come out and went through all the rooms and checked the	F 463			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 463	Continued From page 272 lights on the 19th day of the 6th [June] month. All lights were functioning properly when the company left. They made repairs in several areas. I can't say what happens to the call bells. They seem to get torn out or broken..."	F 463			
F 464 SS=D	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure 1 of 5 (2nd Magoffin dining room) dayroom/dining room was well lite. The findings included: Observations in the 2nd Magoffin dayroom/dining room on 9/10/12 at 5:30 PM, revealed there were two ceiling light fixtures and only one fixture was functioning. The other end of the dayroom was not well lite. Observations on 2nd Magoffin dayroom/dining room on 8:30 AM, 9/18/12 at 8:30 AM, revealed there was only one functioning overhead light. One end of the room was very dimly lite. During an interview in the 2nd Magoffin dayroom	F 464			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 464	Continued From page 273 on 9/20/12 at 8:45 AM, the maintenance verified there was a problem with the lights.	F 464			
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined the facility failed to provide a safe, sanitary and comfortable environment for residents in common areas for 3 of 3 1st McRee, 1st Magoffin and 2nd Magoffin units) units as evidenced by urine and body odors, missing knob from water faucet, hole in wall, dirty baseboard, missing tile and a dirty, unkept shower room. The findings included: 1. Observations during the initial tour on 1st McRee on 9/10/12 at 10:00 AM, revealed the following: a. Strong urine odors on the hall. b. Soiled utility room had several bags of clothes and loose clothing items in a gray rolling hamper with strong urine odors. c. Missing handrail between room 116 and 118. d. Hydro room #1 sink with yellow stains. e. Hydro room #2 (next to room 415) had trash, paper towels and clothes hanging in the whirlpool and no doors on the commode stalls. f. Water fountain missing knob to turn faucet on. g. Hole in floor beside pipe next to ice machine,	F 465			

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F 465	<p>Continued From page 274</p> <p>vent above door not covered, floor dirty, baseboard missing on wall facing doorway.</p> <p>h. Tile missing from wall against dirty utility door frame.</p> <p>i. Soiled utility room with hangers in the sink and on the floor, several bags of clothing items in a gray rolling basket with urine odor, hopper stained and a black bag hanging down in the hopper close to the water.</p> <p>j. Whirlpool room with chipped plastic chair, no curtains, missing wall tile with exposed moldy concrete, dirty toilet, sink stained, floor tiles stained and urine odors in the bathroom.</p> <p>k. Dirty hoyer lift with a torn sheet.</p> <p>l. Closet near room 409 with a loose door knob, floor dirty, dirty rags on shelf, dirty walker and two trays on the floor.</p> <p>m. Clean linen room with a bag of trash on the floor, pillow on floor and a pillow on top of a bag of trash.</p> <p>Observations in the hall on 1st McRee at the entrance to the unit from 1st Cleveland on 9/11/12 at 8:14 AM and 9/13/12 at 4:45 PM, revealed a strong urine odor.</p> <p>2. Observations on 1st Magoffin on 9/10/12 beginning at 10:00 AM, revealed the following:</p> <p>a. Strong urine odor on the hallway.</p> <p>b. Soiled utility room had a strong urine odor dirty gloves on the floor.</p> <p>c. Bathroom just past double doors with chipped paint on rear wall with moldy substance on wallboard, no toilet tissue dispenser, no handle on sink faucets and one handle in the sink.</p> <p>d. Dayroom had a dirty wet blanket on top of air conditioner unit, sticky brown substance noted on front of the unit, broken floor tiles, hanging wire to</p>	F 465			

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F 465	<p>Continued From page 275</p> <p>telephone jack dangling from the wall with exposed wires.</p> <p>e. Storage room with a dirty gerichair, bags of clothes on the floor and dirty gloves on the floor.</p> <p>f. Slanted dead end hall with broken floor tiles and damaged walls.</p> <p>g. Ice cart with sticker marked "clean 9/9" sticker under that sticker marked "clean 8/13".</p> <p>3. Observations on 2nd Magoffin on 9/10/12 beginning at 10:00 AM, revealed the following:</p> <p>a. Strong urine odor on the hallway.</p> <p>b. Room labeled "Authorized personnel only" was unlocked, with a laundry rack with personal clothing on hangers and on the floor and a gerichair with a broken arm and torn seat.</p> <p>c. Soiled linen room with a hopper with water running continuously, unable to turn off and a foul smelling odor in the room.</p> <p>d. Hydro room #1 tub with rust in the drain and an oily substance on the floor at the base of the tub.</p> <p>e. Hydro room #2 had a brown oily substance at the base of the lift.</p> <p>Observations in the hall on 2nd Magoffin, outside rooms 202 and 206 on 9/12/12 at 10:41 AM and 3:40 PM and on 9/17/12 at 10:41 AM, revealed a strong smell of urine and body odors.</p> <p>Observations in the 2nd Magoffin nurses station on 9/13/12 at 4:48 PM, revealed very strong urine odors.</p> <p>Observations in the 2nd Magoffin shower room on 9/17/12 at 12:10 PM, revealed dirty buildup around the edge of the tile floor, the shower door sticking badly and very difficult to open, the inside surface of the wooden paneling on the door</p>	F 465			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 465	Continued From page 276 splitting leaving the bottom of the door with jagged edges and small pieces of chipped off wood on the shower room floor.	F 465			
F 468 SS=D	During an interview on 2nd Magoffin on 9/14/12 at 10:15 AM, the Vice-President and Maintenance Supervisor verified the presence of odors in room 205 and the urine odors on 2nd Magoffin hallway. 483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observations, it was determined the facility failed to ensure the handrails were firmly secured to the walls in 1 of 3 (1st Magoffin) hallways. The findings included: Observations of 1st Magoffin on 9/10/12 at 10:45 AM, on 9/10/12 at 11:15 AM, on 9/11/12 at 2:05 PM, on 9/19/12 at 10:20 AM and on 9/20/12 at 10:00 AM, revealed handrail was loose by room 106, the handrail was loose with holes in the wall holding the mounting screws by rooms 116 and 118, handrail missing between rooms 110 and 112.	F 468			
F 469 SS=F	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents.	F 469			

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

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F 469	Continued From page 277	F 469			
F 490 SS=L	<p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, review of a payroll payout form, review of nursing schedules, review of a time clock slip, review of nursing agency invoices, contract review, review of a job description, pharmacy review, medical record review, observation, and interview, it was determined the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The failure of the facility to be effectively and efficiently administered placed all of the 97 residents residing in the facility in immediate jeopardy (IJ). The Administrator, Facility Consultant, Vice President and the Nursing Supervisor were informed of this IJ on 9/20/12 at 6:00 PM. This IJ was considered present and ongoing at the time of exit.</p>	F 490			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 490	Continued From page 278 The findings included: 1. Review of the "Payroll Payout Form" for August 25, 2012 through September 20, 2012 documented the total of 32.04 hours the Administrator was paid for the 4 week period. Thirty two hours would not total to be even a week of coverage. 2. During an interview in the conference room on 9/13/12 at 10:30 AM the Vice President (VP) and the Administrator were asked who is in charge at this facility. The VP stated the [named management entity] communicates with her, not with the Administrator. The Administrator stated, "I am the licensed Administrator of record." 3. During an interview in the conference room on 9/17/12 at 4:28 PM, the Administrator stated, "We have no Board of Directors or Governing Body... I have not spoken with the new owner, don't have a number or address, have not informed him of the jeopardies. I don't consider this a normal situation... that is how I feel..." 4. The facility failed to ensure that safety measures were implemented to prevent entrapment hazards associated with the use of side rails for 4 of 5 (Residents #6, 13, 84 and 122) residents at risk for entrapment in siderails, which placed these four residents in immediate jeopardy (IJ). The facility failed to ensure a resident at risk for falls had interventions implemented after each fall to prevent further falls for 1 of 3 (Resident #23) sampled residents reviewed with falls, which placed Resident #23 in IJ. The facility failed to ensure the environment was free from accident hazards when 33 of 97	F 490			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 490	<p>Continued From page 279</p> <p>ambulatory residents could come and go unsupervised from their unit and enter through 4 of 4 doors to have access to 2nd McRee (a closed unit) and enter through 2 of 3 doors to 3rd Magoffin that allowed access to stairways and an elevator to enter the closed dark units of 2nd McRee and 3rd Magoffin. The facility failed to provide working smoke detectors for 4 of 68 (room 401, 403, 414 and 219) resident rooms. Refer F323.</p> <p>5. The facility failed to identify, assess, accurately assess, provide treatments and/or use preventive measures to prevent the development of avoidable pressure ulcers for 4 of 4 (Residents #54, 60, 74 and 82) sampled residents at risk of developing pressure ulcers of the 38 residents included in the stage 2 review. Failure of the facility to identify, assess, accurately assess and/or provide care and treatments resulted in an immediate jeopardy (IJ) when Resident #54 and #82 developed avoidable in-house acquired pressure ulcers and Resident #54 and 74's pressure ulcers deteriorated. Refer to F314.</p> <p>6. The facility failed to identify abuse; ensure allegations of abuse an injuries of unknown origin were reported immediately to the Administrator; allegations of abuse and injuries of unknown origin were thoroughly investigated; protect residents during the investigation and report an injury of an unknown origin and allegations of abuse to the state survey office placed Residents #47, 81, 14, 68, 82, and 116 in immediate jeopardy (IJ). Refer to F223, F224, F225 and F226.</p> <p>7. The facility failed to notify the physician of</p>	F 490			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 490	<p>Continued From page 280</p> <p>toxic, critical and abnormal laboratory results; that a swallowing study was not obtained and/or weight loss. The failure of the facility to timely notify the physician of critical and toxic laboratory results or that a swallowing study had not obtained when ordered resulted in the immediate jeopardy (IJ) to Resident #81 and Resident #23. Refer to F157.</p> <p>8. The facility failed to promote care for residents in a manner that maintained or enhanced residents' dignity and respect for 4 of 38 (Residents #82, 6, 30 and 84) sampled residents. The facility failed to maintain dignity and respect of a resident when staff knowingly left her wet with urine during the evening and night shift, which resulted in the development of two new avoidable in house acquired stage II pressure ulcers which caused actual harm to Resident #82. Refer to F241.</p> <p>9. The facility failed to ensure residents received the necessary care and services related to psychiatric services, dental or vision needs for 7 of 38 (Residents #116, 43, 60, 63, 68, 104, and 124) sampled residents. Failure to provide the necessary psychiatric services related to behaviors resulted in an Immediate Jeopardy (IJ) for Resident #116. Refer to F250 and F319.</p> <p>10. The facility failed to provide the necessary care and services to attain or maintain the highest practicable well-being by not following physician orders for obtaining laboratory (lab) tests, a swallowing study, providing treatments, administering medications, conducting a 3 day calorie count or timely notifications of lab results to the physician for 7 of 31 (Residents #81, 23,</p>	F 490			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 490	<p>Continued From page 281</p> <p>28, 43, 84, 104, and 124) sampled residents of the 38 residents included in the stage 2 review. The failure of the facility to obtain laboratory tests and a swallowing study, provide treatments and notify the physician of abnormal lab results timely resulted in the immediate jeopardy (IJ) to Resident #81. The failure of the facility to obtain lab tests as ordered resulted in the immediate jeopardy of Residents #23. Refer to F309.</p> <p>11. The facility failed to ensure care plan interventions were followed for laboratory, dental, pressure ulcer, nutrition, rehabilitation, activities of daily living (ADL), accident prevention, restraints, unnecessary medications, range of motion (ROM), vision and/or falls for 12 of 31 (Residents #23, 81, 82, 74, 21, 28, 43, 63, 84, 104, 118 and 124) sampled residents of the 38 residents included in the stage 2 review. The facility failed to follow care plan interventions for fall preventive program; obtain, monitor and report abnormal laboratory levels as ordered, and perform wound care and ADL care as ordered placed Residents #23, 81, 82 and 74 in immediate jeopardy. Refer F282.</p> <p>12. The facility failed to ensure there was sufficient and competent nursing staff on 3 of 3 (1st McRee, 1st Magoffin and 2nd Magoffin units) nursing units to ensure residents were provided with the necessary care and services to meet their highest level of well-being. The facility failed to ensure adequate and competent nursing staff as evidenced by 4 of 6 (Nurses #2, 6, 7 and 9) nurses observed administering medications had a medication error rate 15.517 percent (%). The facility failed to ensure an adequate and competent nursing staff as evidenced by expired</p>	F 490			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 490	<p>Continued From page 282</p> <p>medications were available for use and having incorrect narcotic counts in 3 of 8 (1st McRee medication cart, 1st Magoffin West medication cart and 1st Magoffin medication room) medication storage areas. The facility failed to ensure adequate and competent nursing assessed, identified, and provided treatments for pressure ulcers for Residents #54, 60, 74, and 82. The failure of the facility to maintain an adequate and competent nursing staff resulted in immediate jeopardy (IJ) for all residents residing in the facility. Refer to F353.</p> <p>13. The facility failed to ensure there was a Registered Nurse (RN) that worked at least 8 consecutive hours a day, 7 days a week. Refer to F354.</p> <p>14. The facility failed to ensure that 2 of 31 (Residents #101 and 124) sampled residents of the 38 included in the stage 2 review received nutritional management to assess and develop approaches to maintain the resident's nutritional status. The failure to provide nutritional intervention for residents with significant weight loss resulted in actual harm for Residents #101 and 124. Refer to F325.</p> <p>15. The facility failed to ensure a Registered Dietitian (RD) assessed and implemented interventions that addressed nutritionally compromised residents with significant weight loss which resulted in actual harm for 2 of 38 (Residents #101 and 124) sampled residents included in the stage 2 review. Refer to F361.</p> <p>16. The facility failed to ensure the physician was promptly notified of toxic and critical laboratory</p>	F 490			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 490	<p>Continued From page 283</p> <p>tests results and failed to notify the physician when laboratory tests were not obtained as ordered for 2 of 38 (Residents #81 and 23) sampled residents included in the stage 2 review. The failure of the facility to promptly notify the physician of toxic and critical laboratory (lab) tests results and notify the physician when laboratory tests were not obtained as ordered resulted in the Immediate Jeopardy to Resident #81 and #23. Refer to F502 and F505.</p> <p>17. The facility failed to ensure the Medical Director assisted the facility with identifying, evaluating, and addressing clinical concerns, coordinate the medical care and provide clinical guidance and oversight regarding the implementation of resident care policies and procedures that reflect the current standards of practice for the 97 residents residing in the facility. The failure of the facility to ensure the Medical Director assisted with addressing clinical concerns, and provided guidance regarding resident care placed the 97 residents residing in the facility in immediate jeopardy (IJ). Refer F501.</p> <p>18. The facility failed to provide housekeeping and effective maintenance services to maintain a sanitary, orderly and comfortable environment as evidenced by baseboards peeling from the wall and torn baseboards in bathrooms, scuff marks on walls, dust on personal fan blades, cracked and missing tiles, torn curtains, curtains with holes, missing hooks and curtains with brown stains, non working sink faucets, leaking faucets, non working air condition (AC) units with broken panels and missing dials, non working over bed lights, window curtains with torn hems, wet, dirty and brown stain towels in a sink on 3 of 3 (1st</p>	F 490			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 490	Continued From page 284 Magoffin, 2nd Magoffin and 1st McRee) units The facility's failure to provide effective maintenance and housekeeping services to maintain a sanitary, orderly and comfortable environment resulted in substandard quality of care. Refer to F253.	F 490			
F 493 SS=L	19. The facility failed to ensure bed linens were clean and in good condition on 3 of 3 (1st McRee, 1st Magoffin and 2nd Magoffin) units. Refer to F254. 483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on policy review, review of a payroll payout form, review of a time slip, review of nursing schedules, review of nursing agency invoices, contract review, time clock forms, review of a job description for the Social Worker, pharmacy review, medical record review, observation, and interview, it was determined the facility failed to have a governing body or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the	F 493			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 493	<p>Continued From page 285</p> <p>management and operation of the facility. The failure of the facility to ensure a governing body that established and implemented policies regarding the management and operation of the facility placed all of the 97 residents residing in the facility were placed in the immediate jeopardy (IJ). The Administrator, Facility Consultant, Vice President and the Nursing Supervisor were informed of this IJ on 9/20/12 at 6:00 PM. This IJ was considered present and ongoing at the time of exit.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. During an interview in the conference room on 9/17/12 at 4:28 PM, the Administrator stated, "We have no Board of Directors or Governing Body... I have not spoken with the new owner, don't have a number or address, have not informed him of the jeopardies, I don't consider this a normal situation but when your left that is how I feel..." 2. The facility failed to have a governing body that established and implemented policies regarding the management and operation of the facility and provided oversight of the management and operation of the facility. Refer to F490. 3. The facility failed to ensure that safety measures were implemented to prevent entrapment hazards associated with the use of side rails for 4 of 5 (Residents #6, 13, 84 and 122) residents at risk for entrapment in siderails, which placed these four residents in immediate jeopardy (IJ). The facility failed to ensure a resident at risk for falls had interventions implemented after each fall to prevent further falls for 1 of 3 (Resident #23) sampled residents 	F 493			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 493	<p>Continued From page 286</p> <p>reviewed with falls, which placed Resident #23 in IJ. The facility failed to ensure the environment was free from accident hazards when 33 of 97 ambulatory residents could come and go unsupervised from their unit and enter through 4 of 4 doors to have access to 2nd McRee (a closed unit) and enter through 2 of 3 doors to 3rd Magoffin that allowed access to stairways and an elevator to enter the closed dark units of 2nd McRee and 3rd Magoffin. The facility failed to provide working smoke detectors for 4 of 68 (room 401, 403, 414 and 219) resident rooms. Refer F323.</p> <p>4. The facility failed to ensure adequate and competent nursing staff that assessed/accurately assessed, to prevent avoidable pressure ulcer from developing and timely identified pressure ulcers placed Resident's #54, 74, and 82 in IJ. Refer to F314.</p> <p>5. The facility failed to ensure that residents were free form physical, verbal, and resident to resident abuse by failing to report allegations to management; failing to protect residents; failing to investigate and report allegations of abuse and an injury of unknown origin to the state survey agency. Refer to F223, F224, F225, and F226.</p> <p>6. The facility failed to ensure that laboratory tests and a swallowing study were obtained timely, failed to timely notify the physician of toxic and critical laboratory results, failed to notify the physician of tests not obtained as ordered, failed to investigate and treat injuries of unknown origin. Refer to F157 and F309.</p> <p>7. The facility failed to promote care for residents</p>	F 493			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 493	<p>Continued From page 287</p> <p>in a manner that maintained or enhanced residents' dignity and respect for 4 of 38 (Residents #82, 6, 30 and 84) sampled residents. The facility failed to maintain dignity and respect of a resident when staff knowingly left her wet with urine during the evening and night shift, which resulted in the development of two new avoidable in house acquired stage II pressure ulcers which caused actual harm to Resident #82. Refer to F241.</p> <p>8. The facility failed to ensure medically related social services addressed psychiatric, behaviors, dental and vision needs of residents. Refer to F250 and F319.</p> <p>9. The facility failed to ensure care plan interventions were followed for laboratory, dental, pressure ulcer, nutrition, rehabilitation, activities of daily living (ADL), accident prevention, restraints, unnecessary medications, range of motion (ROM), vision and/or falls for 12 of 31 (Residents #23, 81, 82, 74, 21, 28, 43, 63, 84, 104, 118 and 124) sampled residents of the 38 residents included in the stage 2 review. The facility failed to follow care plan interventions for fall preventive program; obtain, monitor and report abnormal laboratory levels as ordered, and perform wound care and ADL care as ordered which placed Residents #23, 81, 82 and 74 in immediate jeopardy. Refer F282.</p> <p>10. The facility failed to ensure there was sufficient and competent nursing staff on 3 of 3 (1st McRee, 1st Magoffin and 2nd Magoffin units) nursing units to ensure residents were provided with the necessary care and services to meet their highest level of well-being. The facility failed</p>	F 493			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 493	<p>Continued From page 288</p> <p>to ensure adequate and competent nursing staff as evidenced by 4 of 6 (Nurses #2, 6, 7 and 9) nurses observed administering medications had a medication error rate 15.517 percent (%). The facility failed to ensure an adequate and competent nursing staff as evidenced by expired medications were available for use and having incorrect narcotic counts in 3 of 8 (1st McRee medication cart, 1st Magoffin West medication cart and 1st Magoffin medication room) medication storage areas. The facility failed to ensure adequate and competent nursing assessed, identified, and provided treatments for pressure ulcers for Residents #54, 60, 74, and 82. The failure of the facility to maintain an adequate and competent nursing staff resulted in immediate jeopardy (IJ) for all residents residing in the facility. Refer to F353.</p> <p>11. The facility failed to ensure there was a Registered Nurse (RN) that worked at least 8 consecutive hours a day, 7 days a week. Refer to F354.</p> <p>12. The facility failed to ensure the physician was promptly notified of toxic and critical laboratory tests results and failed to notify the physician when laboratory tests were not obtained as ordered for 2 of 38 (Residents #81 and 23) sampled residents included in the stage 2 review. The failure of the facility to promptly notify the physician of toxic and critical laboratory (lab) tests results and notify the physician when laboratory tests were not obtained as ordered resulted in the Immediate Jeopardy to Resident #81 and #23. Refer to F502 and F505.</p> <p>13. The facility failed to ensure the Medical</p>	F 493			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 493	<p>Continued From page 289</p> <p>Director assisted the facility with identifying, evaluating, and addressing clinical concerns, coordinate the medical care and provide clinical guidance and oversight regarding the implementation of resident care policies and procedures that reflect the current standards of practice for the 97 residents residing in the facility. The failure of the facility to ensure the Medical Director assisted with addressing clinical concerns, and provided guidance regarding resident care placed the 97 residents residing in the facility in immediate jeopardy (IJ). Refer F501.</p> <p>14. The facility failed to ensure residents received adequate nutritional management to prevent unplanned significant weight loss. Refer to F325 and F361.</p> <p>15. The facility failed to provide housekeeping and effective maintenance services to maintain a sanitary, orderly and comfortable environment as evidenced by baseboards peeling from the wall and torn baseboards in bathrooms, scuff marks on walls, dust on personal fan blades, cracked and missing tiles, torn curtains, curtains with holes, missing hooks and curtains with brown stains, non working sink faucets, leaking faucets, non working air condition (AC) units with broken panels and missing dials, non working over bed lights, window curtains with torn hems, wet, dirty and brown stain towels in a sink on 3 of 3 (1st Magoffin, 2nd Magoffin and 1st McRee) units The facility's failure to provide effective maintenance and housekeeping services to maintain a sanitary, orderly and comfortable environment resulted in substandard quality of care. Refer to F253.</p>	F 493			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 493	Continued From page 290 16. The facility failed to ensure bed linens were clean and in good condition on 3 of 3 (1st McRee, 1st Magoffin and 2nd Magoffin) units. Refer to F254. 17. The facility failed to ensure adequate and competent nursing staff to provide the care and services of all residents, failed to ensure nursing staff were competent to administer medications without a 20.688% error rate, and failed to ensure nursing staff were competent to administer medications without significant medications error. The facility failed to ensure nursing staff that ensured medications were not stored after their expiration date and there were accurate narcotic reconciliation. Refer to F332 and F431.	F 493			
F 497 SS=F	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by:	F 497			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 497	Continued From page 291 Based on review of Licensed Practical Nurse (LPN) job description, review of employee personnel files and interview, it was determined the facility failed to ensure annual performance evaluations were completed on 40 of 40 Certified Nursing Assistants (CNAs). The findings included: Review of the LPN job description documented, "...Supervises and evaluates work performance in terms of patient care, staff relations and efficiency of service..." Review of the forty CNA employee personnel files revealed there was no documentation of performance evaluations. During an interview in the conference room on 9/13/12 at 10:02 AM, the Director of Nursing was asked about performance evaluations for CNAs. The Director of Nursing stated, "No performance evaluations done [for CNAs] the last three years..."	F 497			
F 498 SS=F	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on review of employee personnel files and interview, it was determined the facility failed to	F 498			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 498	Continued From page 292 ensure that competency checks for skills were performed on 40 of 40 Certified Nursing Assistants (CNAs). The findings included: Review of the forty CNA employee personnel files revealed there was no documentation of competency checks of skills for the CNAs. During an interview in the conference room on 9/13/12 at 10:00 AM, the Director of Nursing (DON) was asked about competency checks for CNAs. The DON stated, "No... competency checks done [for CNAs] the last three years..."	F 498			
F 500 SS=D	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h) (2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. This REQUIREMENT is not met as evidenced	F 500			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 500	Continued From page 293 by: Based on review of facility's dialysis contract and interview, it was determined the facility failed to ensure the dialysis contract specified the services provided to the facility for 1 of 3 (Resident #96) sampled residents receiving dialysis services included in the stage 2 review. The findings included: Review of the facility's dialysis contract documented, "[Named dialysis clinic] Please be advised that [named dialysis clinic] by special arrangements with [name of nursing home], provided total dialysis services to the facility residents, who require such procedures..." The facility was unable to provide a contract that specified the services provided by the dialysis clinic. During an interview in the conference room on 9/12/12 at 10:00 AM, the Administrator was asked if he had any other parts to the dialysis contract. The Administrator stated, "No, that's all I got."	F 500			
F 501 SS=L	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced	F 501			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 501	<p>Continued From page 294</p> <p>by: Based on contract review, policy review, review of a payroll payout form, review of the facility's working nursing schedule, review of nursing agency invoices, contract review, review of a job description for the Social Worker, time clock forms, pharmacy review, medical record review, observation, and interview, it was determined the facility failed to ensure the Medical Director assisted the facility with identifying, evaluating, and addressing clinical concerns, coordinate the medical care and provide clinical guidance and oversight regarding the implementation of resident care policies and procedures that reflect the current standards of practice for the 97 residents residing in the facility. The failure of the facility to ensure the Medical Director assisted with addressing clinical concerns, and provided guidance regarding resident care placed the 97 residents residing in the facility in immediate jeopardy (IJ). The Administrator, Facility Consultant, Vice President and the Nursing Supervisor were informed of this IJ on 9/20/12 at 6:00 PM. This IJ was considered present and ongoing at the time of exit.</p> <p>The findings included:</p> <p>Review of the Medical Director's contract dated 6/27/12 documented, "...6. Develop, recommend and implement appropriate clinical practices and medical care polices that help to ensure that each resident's medical regime is a [an] integral part of the interdisciplinary plan of care. 7. Review accident and/or incident reports to identify potential health and safety hazards at [name of facility] and recommend and/or consult with the Administrator and /or Director of Nursing in</p>	F 501			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 501	Continued From page 295 helping resolve those issues..." During an interview in the administrative office on 9/14/12 at 11:00 AM, the Medical Director stated, "I am not aware of jeopardy's, was surprised you all are still here. I am the medical director here, started a couple of months ago, I talk with the Administrator every time I visit... I don't remember if I got a job description, I did get a contract with lots of papers, papers are papers, I don't remember a job description. I am part of the QA [quality assurance] committee here, other facilities I have they discuss wounds, incidents, falls, weight loss and other things. I am not interested in such as maintenance. I do not have an office, my office is my briefcase and car, my practice is several nursing homes, assisted livings, and I make some house calls." During an interview in the Administrator's Office on 9/20/12 at 1:40 PM the Administrator stated, "The QA committee meeting is conducted by the Medical Director and all department heads participate... the meetings are conducted monthly... issues recently addressed by the QA committee were falls, weights, infections, and behaviors... once identified interventions are put in place, there is a monitoring process..." The facility failed to ensure the Medical Director provided oversight in addressing clinical concerns, assisted with providing guidance for the medical care of the 97 residents residing in the facility. Refer to F157, 223, 224, 225, 226, 241, 250, 309, 314, 319, 323, 325, 332, 353, 361 and F520.	F 501			
F 502 SS=J	483.75(j)(1) ADMINISTRATION	F 502			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 502	<p>Continued From page 296</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, and interview, it was determined the facility failed to ensure that laboratory tests were obtained as ordered for 7 of 38 (Residents #81, 23, 28, 43, 47, 84 and 104) sampled residents reviewed included in the stage 2 review. The failure of the facility to obtain laboratory (lab) tests as ordered results in the immediate jeopardy to Resident #81 and 23. The Administrator and Director of Nursing were informed of this IJ identified on 9/14/12 at 1:20 PM. The facility provided surveyors with a written response on 9/14/12 at 5:30 PM, for process for obtaining ordered laboratory tests. This written response was determined to be unacceptable on 9/14/12. The IJ was considered present and ongoing at the time of exit.</p> <p>The findings included:</p> <p>1. Review of the facility "LAB POLICY" documented, "...PURPOSE: To provide adequate interventions to maintain stable health conditions... D. The LPN [Licensed Practical Nurse] will review lab [laboratory] results and contact the Md [Medical Doctor]. The LPN will document in the nurse's note whom, when and what information provided to MD with notation of any orders... L. The MD is to be notified of all critical lab values immediately. M. If no response</p>	F 502			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 502	<p>Continued From page 297</p> <p>from MD in (1) hour, the Nursing Supervisor is to be called. If still no response the DON is to be notified..."</p> <p>2. Medical record review for Resident #81 documented an admission date of 6/15/07 and readmitted on 7/16/12 with diagnoses of Above the Knee Amputation, Cerebrovascular Accident, Hypertension, Vascular Dementia, and Peripheral Vascular Disease. A physician's order dated 7/16/12 documented "Warfarin 3 mg [milligrams] QD [every day] and Warfarin 10 mg QHS [every night]" A physician's order dated 7/26/12 documented "monthly PT/INR [prothrombin time/normalized international ratio]." The annual Minimum Data Set (MDS) dated 8/16/12 documented the resident is on daily anticoagulants.</p> <p>The care plan dated dated 3/30/11 and updated on 8/22/12 documented, "...Potential for bleeding related to anticoagulant therapy... 3. Obtain lab work as ordered by MD..."</p> <p>The July 2012 Medication Administration Record (MAR) documented the resident received a total of Warfarin 13 mg daily from 7/16/12 to (-) 7/31/12. The August 2012 MAR documented the resident received a total of Warfarin 13 mg daily from 8/1/12-8/31/12. The September 2012 MAR documented the resident received Warfarin 13 mg daily 9/1/12-9/13/12.</p> <p>The facility was unable to provide documentation of PT/INR lab results as ordered.</p> <p>During an interview in the conference room on 9/12/12 at 5:30 PM, the Director of Nursing</p>	F 502			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 502	<p>Continued From page 298</p> <p>(DON) stated, "Unable to find any PT/INR's since his return from the hospital [7/16/12]."</p> <p>The facility obtained a PT/INR on 9/13/12 after the surveyor had asked about PT/INR results.</p> <p>On 9/14/12 at 7:40 AM, Nurse #3 brought in the results of the PT/INR that was done on 9/13/12. The PT/INR lab results drawn on 9/13/12 were abnormally high. The PT was 43.1 seconds (normal PT is 11.6-14.4 seconds) and the INR value was 4.98 (normal INR is 1.4 or less).</p> <p>During an interview in the conference room on 9/14/12 at 7:50 AM, the DON was asked what the procedure for notifying the physician was. The DON stated, "Staff are to call the physician and keep calling till [until] they get a response. If no response then they are to notify the supervisor or me. I got no call about this."</p> <p>During an interview conducted in the conference room on 9/14/12 at 8:00 AM, the Nurse #4 stated, "I have talked with [named physician] it was reported late yesterday [9/13/12] and just got the lab values faxed back this morning from the lab. He [MD] ordered PT/INR every other day. I am going to draw another one today..."</p> <p>Review of a nurse's note dated 9/14/12 at 8:15 AM documented, "Called [named physician] R/E [related to] abnormal lab values. New order obtained, states he will be here this AM, PT/INR critical." There was no further documentation concerning the abnormal high lab result until a physician's order dated 9/14/12 at 8:15 AM documented, "Hold Coumadin for now, collect PT/INR every other day."</p>	F 502			

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

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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	
F 502	<p>Continued From page 299</p> <p>During an interview in the administrative office on 9/14/12 at 11:00 AM, the Physician/Medical Director was asked about the abnormal high PT/INR. The attending Physician/Medical Director stated, "I got a message from my answering service about 7:00 PM yesterday [9/13/12]. I called back and no one picked up." The surveyor asked if not answering the phone happened often. The attending Physician/Medical Director stated, "Yes, that has happened before [not answering phone] but I know the nurses would contact me again if it was something serious or send patient to hospital. I saw the patient [Resident #81] this morning, ordered to hold coumadin and check PT/INR's until down to 3 then to restart Coumadin 10 mg daily... I was not aware that Coumadin 13 mg was given daily since readmission... My therapeutic INR goal is 2-3 for this patient..."</p> <p>The facility failed to obtain monthly PT/INR labs as ordered placed Resident #81 in IJ.</p> <p>3. Medical record review for Resident #23 documented an admission date of 1/29/99 with diagnoses of Subarachnoid Hemorrhage, Diabetes, Hemiplegia, Dementia, Hypertension and Seizure Disorder and a readmission date of 9/10/12 with a new diagnosis of Dilantin Toxicity. Review of a physician's order dated 8/12/12 documented, "...Add Dilantin 100 mg in A.M.; continue 400 mg HS [hour of sleep]; check Dilantin levels in 2 wks [weeks]..." Review of a physician's order dated 9/2/12 documented, "...Dilantin level, CBC [Complete Blood Count], CMP [Complete Metabolic Profile], Urine C&S [Culture and Sensitivity]..."</p>	F 502			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 502	<p>Continued From page 300</p> <p>The facility was unable to provide documentation that the lab results for Dilantin level, CBC, CMP, Urine C&S had been done as ordered.</p> <p>Review of a hospital history and physical dated 9/5/12 documented, "...Dilantin of 31.2, normal is 10-20... admitted to the hospital with diagnosis of Dilantin toxicity... Dilantin was put on hold..."</p> <p>Review of a physician's order dated 9/10/12 documented, "...Readmit to [name of facility] post Dilantin Toxicity..."</p> <p>During an interview in the conference room on 9/13/12 at 8:00 AM, Nurse #3 was asked about the missing Dilantin results. Nurse #3 stated, "...I called the lab today and they faxed a Dilantin level that was done on 8/30/12..." Nurse #3 was asked if the physician had been notified of the 8/30/12 Dilantin level. Nurse #3 stated, "...I don't know..."</p> <p>Review of the Dilantin level completed on 8/30/12 and faxed on 9/13/12 documented a high Dilantin level of 28.8. The therapeutic reference range was 10-20.</p> <p>During an interview in the administrative office on 9/14/12 at 11:00 AM, the attending physician / medical director was asked if the facility had notified him of the 28.8 Dilantin level. The medical director stated, "...No, if I had known the levels were high, I would have decreased the Dilantin..."</p> <p>During an interview in the DON's office on 9/14/12 at 1:00 PM, the DON was asked about the failure to notify the physician of the elevated</p>	F 502			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 502	<p>Continued From page 301</p> <p>Dilantin level. The DON stated, "...lab has been a big issue..."</p> <p>The facility failed to obtain Dilantin levels as ordered placed Resident #23 in IJ.</p> <p>4. Medical record review for Resident #28 documented an admission date of 11/24/99 and a readmission date of 4/12/11 with diagnoses of Gastroentroenteritis, Renal Insufficiency, Back Pain, Diabetes Mellitus, Hypertension, Cerebrovascular Accident, Epilepsy, Bipolar Disorder, and Cognitive Dementia. Review of the physician orders dated 8/4/12 documented, obtain "...BMP [Basic Metabolic Panel], HGBAIC [glycosylated Hemoglobin A1c], DEPAKOTE LEVEL, EVERY... MONTHS... FEB [February], MAY, AUG [August], NOV [November]..."</p> <p>Review of the "Consultant Pharmacist Administrative Report" dated 6/13/12 documented, "...past due labs... BMP, Lipid Panel, HgbA1c, Depakote... ordered q [every] 3 months... was due May 2012..."</p> <p>The facility was unable to provide documentation that the BMP, HgbA1C and Depakote level were obtained as ordered.</p> <p>During an interview in the conference room on 9/18/12 at 8:50 AM, Nurse #4 was asked if there was a reason the labs would not have been drawn in May 2012. Nurse #4 stated, "...I can't think of any reason..."</p> <p>5. Medical record review for Resident #43 documented an admission date 12/22/09 with diagnoses of Vascular Dementia with Delusions,</p>	F 502			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 502	<p>Continued From page 302</p> <p>Hypertension, Diabetes Mellitus, Alcohol Abuse, Convulsions, Cerebrovascular Accident, and Left Hemiparesis. Review of the physician's orders dated 6/6/12 documented, "...DILANTIN [Phenytoin] LEVEL EVERY 3 MONTHS (MAY/AUG/NOV/FEB)..."</p> <p>Review of the "Consultant Pharmacist Administrative Report" dated 6/13/12 documented, "...following lab(s) past due... Phenytoin... ordered every 3 months... was due May 2012... "</p> <p>The facility was unable to provide documentation that the Dilantin level was not done as ordered.</p> <p>During an interview in the conference room on 9/18/12 at 8:50 AM, Nurse #4 was asked if there was a reason that the lab would not have been drawn in May 2012. Nurse #4 stated, "...I can't think of any reason..."</p> <p>6. Medical record review for Resident #47 documented the resident admitted on 7/27/09 with diagnoses of Spina Bifida, Paraplegia, Anemia, Gastrointestinal Hemorrhage, Major Depressive Disorder with Psychosis and Hypertension. A physician's order dated 8/1/12 documented "BMP [Basic Metabolic Panel] quarterly and PT/INR monthly."</p> <p>The facility was unable to provide labs results for an august 2012 BMP and PT/INR. The facility failed to obtain the BMP and PT/INR that was ordered for August 2012.</p> <p>7. Medical record review for Resident #84 documented an admission date of 4/11/08 with</p>	F 502			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER AMERICARE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3391 OLD GETWELL RD MEMPHIS, TN 38118		
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F 502	<p>Continued From page 303</p> <p>diagnoses of Senile Dementia, Esophageal Reflux, Osteoporosis, Hypertension, and Closed Fracture of Lumbar Spine. Review of a physician's order dated 8/19/12 documented, "...GGT [Gamma glutamyl transferase] lab test..."</p> <p>Review of a history and physical dated 8/19/12 documented, "...Impression: R/O [rule out] liver disease... Plan: GGT to rule out liver disease as source of ^ [increased] alk [alkaline] phos [phosphatase]..."</p> <p>The facility was unable to provide lab results for a GGT as ordered in August 2012.</p> <p>During an interview in the medical records office on 9/19/12 at 3:30 PM, medical records director was asked about the GGT results. The medical records director stated, "...we cannot locate them [GGT lab results]..."</p> <p>8. Medical record review for Resident #104 documented an admission date of 8/2/11 with diagnoses of Schizophrenia, Dementia, Diabetes Mellitus, Seizure Disorder and Tardive Dyskinesia. A readmission date of 5/16/12 with new diagnoses of Subdural Hematoma and Percutaneous Endoscopy Gastrostomy Tube. Review of a physician's order dated 10/8/11 documented, "...CBC c [with] DIFFERENTIAL q [every] 2 WEEKS..."</p> <p>Review of a physician's order dated 11/4/11 documented, "...Pt [patient] should be having a WBC [white blood count] with differential every 2 weeks. Has not been being done. WBC with diff [differential] q 2 weeks..."</p>	F 502			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 502	Continued From page 304 Review of a physician's order dated 11/15/11 documented, "...BE SURE AND DO A WBC c DIFFERENTIAL ON 11-17-11..." Review of a physician's order dated 11/30/11 documented, " ...WE NEED CBC c DIFFERENTIAL REPORT FROM 11-17-11 ON THE CHART. CONTINUE CBC c DIFFERENTIAL EVERY 2 WEEKS. PT. [patient] IS ON CLOZARIL AND WE NEED TO CHECK FOR NEUTROPENIA PERIODICALLY. THAT'S WHY WE DO THE CBC's AND DIFFERENTIALS TO TRY TO AVOID INFECTIONS..." The facility was unable to provide documentation of lab results for the CBC and WBC with differentials as ordered. During an interview in the DON's office on 9/14/12 at 12:20 PM, the DON was asked about the lab reports which were unavailable. The DON stated, "...lab has been a big issue..."	F 502			
F 505 SS=J	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and interview, it was determined the facility failed to ensure the physician was promptly notified of toxic and critical laboratory tests results and failed to notify the physician when laboratory tests were not obtained as ordered for 2 of 38 (Residents #81 and 23) sampled residents included in the	F 505			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 505	<p>Continued From page 305</p> <p>stage 2 review. The failure of the facility to promptly notify the physician of toxic and critical laboratory (lab) tests results and notify the physician when laboratory tests were not obtained as ordered resulted in the immediate jeopardy to Resident #81 and #23. The Administrator and Director of Nursing were informed of this IJ identified on 9/14/12 at 1:20 PM. The facility provided surveyors with a written response on 9/14/12 at 5:30 PM for notifying the physician of critical laboratory test results. This written response was determined to be unacceptable on 9/14/12. The IJ was considered present and ongoing at the time of exit.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility "LAB POLICY" documented, "...PURPOSE: To provide adequate interventions to maintain stable health conditions... D. The LPN [Licensed Practical Nurse] will review lab results and contact the Md [Medical Doctor]. The LPN will document in the nurse's note whom, when and what information provided to MD with notation of any orders... L. The MD is to be notified of all critical lab values immediately. M. If no response from MD in (1) hour, the Nursing Supervisor is to be called. If still no response the DON is to be notified..." 2. Medical record review for Resident #81 documented an admission date of 6/15/07 and readmitted on 7/16/12 with diagnoses of Cerebral Vascular Accident, Hypertension, Above the Knee Amputation, Vascular Dementia, and Peripheral Vascular Disease. A physician's order dated 7/16/12 documented "Warfarin [Coumadin] 3 mg [milligrams] QD [every day] and Warfarin 10mg 	F 505			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 505	<p>Continued From page 306</p> <p>QHS [every night]" A physician's order dated 7/26/12 documented, "monthly PT/INR [prothrombin time/normalized international ratio]."</p> <p>The facility was unable to provide lab results of the ordered monthly PT/INR.</p> <p>During an interview in the conference room on 9/12/12 at 5:30 PM, the Director of Nursing (DON) stated, "Unable to find any PT/INR's since his [Resident #81] return from the hospital [7/16/12]."</p> <p>The facility obtained a PT/INR on 9/13/12 after the surveyor had asked for PT/INR results.</p> <p>On 9/14/12 at 7:40 AM, Nurse #3 brought in the results of the PT/INR that was done on 9/13/12. The PT/INR lab results drawn on 9/13/12 were abnormally high. The PT was 43.1 seconds (normal PT is 11.6-14.4 seconds) and the INR value was 4.98 (normal INR is 1.4 or less).</p> <p>During an interview in the conference room on 9/14/12 at 7:50 AM, the DON was asked what the procedure was for notifying the physician of lab results. The DON stated, "Staff are to call the physician and keep calling till [until] they get a response. If no response then they are to notify the supervisor or me. I got no call about this."</p> <p>During an interview in the conference room on 9/14/12 at 8:00 AM, the Nurse #4 stated, "I have talked with [named attending physician] it was reported late yesterday [9/13/12] and just got the lab values faxed back this morning from the lab. He [MD] ordered PT/INR every other day. I am going to draw another one [PT/INR] today..."</p>	F 505			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 505	<p>Continued From page 307</p> <p>A nurse's note dated 9/14/12 at 8:15 AM documented, "Called [named physician] R/E [related to] abnormal lab values. New order obtained, states he will be here this AM, PT/INR critical." There was no further documentation concerning the abnormal high lab result until a physician's order dated 9/14/12 at 8:15 AM documented, "Hold Coumadin for now, collect Pt/INR every other day."</p> <p>During an interview in the administrative office on 9/14/12 at 11:00 AM, concerning the abnormal high PT/INR, the Physician/Medical Director stated, "I got a message from my answering service about 7:00 PM yesterday [9/13/12]. I called back and no one picked up. Yes, that has happened [not answering the phone] before but I know the nurses would contact me again if it was something serious or send patient to hospital. I saw the patient [Resident #81] this morning [9/14/12], ordered to hold coumadin [warfarin]and check PT/INR's until down to 3 then to restart Coumadin 10mg daily... I was not aware that Coumadin 13mg was given daily since readmission... My therapeutic INR goal is 2-3 for this patient..."</p> <p>A nurse's note dated 9/14/12 time 3-11 documented, "Received critical lab. Made MD aware by leaving message. Awaiting return call..."</p> <p>The failure of the facility to promptly notify the physician of test results resulted in the immediate jeopardy of Resident #81.</p> <p>3. Medical record review for Resident #23 documented an admission date of 1/29/99 with</p>	F 505			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 505	<p>Continued From page 308</p> <p>diagnoses of Subarachnoid Hemorrhage, Hemiplegia, Diabetes, Dementia, Hypertension and Seizure Disorder and a readmission date of 9/10/12 with a new diagnosis of Dilantin Toxicity. Review of a physician's order dated 8/12/12 documented, "...check Dilantin levels in 2 wks..."</p> <p>Review of a physician's order dated 9/2/12 documented, "...Dilantin level, CBC [Complete Blood Count], CMP [Complete Metabolic Profile], Urine C&S [Culture and Sensitivity]..."</p> <p>The facility was unable to provide lab results for Dilantin levels, CBC, CMP or Urine C&S.</p> <p>Review of a physician's order dated 9/5/12 documented, "...Send to [named hospital] ER [emergency room] for eval [evaluation] of head due to fall on concrete..."</p> <p>Review of a history and physical [from named hospital] dated 9/5/12 documented, "...Dilantin of 31.2, normal is 10- [to] 20... admitted to the hospital with diagnosis of Dilantin toxicity... Dilantin was put on hold..."</p> <p>Review of a physician's order dated 9/10/12 documented, "...Readmit to [name of the facility] post Dilantin Toxicity..."</p> <p>During an interview in the conference room on 9/13/12 at 8:00 AM, Nurse #3 was asked about the missing Dilantin results. Nurse #3 stated, "...I called the lab today and they faxed a Dilantin level that was done on 8/30/12..." Nurse #3 was asked if the physician had been notified of the 8/30/12 Dilantin level results. Nurse #3 stated, "...I don't know..."</p>	F 505			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 505	Continued From page 309 Review of the Dilantin level completed on 8/30/12 and faxed on 9/13/12 documented a Dilantin level of 28.8. The therapeutic reference range was 10-20. During an interview in the administrative office on 9/14/12 at 11:00 AM, the medical director was asked if the facility had notified him of the 28.8 Dilantin level. The medical director stated, "...No, if I had known the levels were high, I would have decreased the Dilantin..." During an interview in the DON's office on 9/14/12 at 1:00 PM, the DON was asked about the failure to notify the physician of the elevated Dilantin level. The DON stated, "...we have been having problems with lab..." The facility's failure to obtain, monitor and report Dilantin levels as ordered resulted in immediate jeopardy to Resident #23 who was readmitted to the facility on 9/10/12 with a new diagnosis of Dilantin Toxicity.	F 505			
F 516 SS=D	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or	F 516			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 516	<p>Continued From page 310 unauthorized use.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, and interview, it was determined the facility failed to ensure that private health information was protected for 1 of 38 (Resident #81) residents reviewed included in the stage 2 review.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Review of the facility's Health Insurance Portability and Accountability Act policy (HIPPA) policy documented "...it is a law put in place and regulated by the federal government to protect a client's privacy and personal information... examples of information we need to protect and ensure confidentiality is used... age, social security number, diagnosis, financial info, insurance status, lab an test results...Upon admission the Responsible Party or Health Care Surrogate designates who can have assess to the resident's information... limit information given over the telephone..." Medical record review for Resident #81 documented an admission date of 6/15/07 and readmitted 7/16/12 with diagnoses of Cerebral Vascular Accident, Hypertension, Vascular Dementia, Above the Knee Amputation of left leg, and Peripheral Vascular Disease. Resident #81's responsible party on admission was the sister in law. <p>During a family interview in the conference room on 9/11/12 at 10:30 AM, a family of Resident #81</p>	F 516			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 516	<p>Continued From page 311</p> <p>stated, "[Named admissions clerk #1] forged [named family member's sister in law's] signature to get Responsible Party [RP] switched over to [named family member] a cousin. The sister in law was the RP on admission from hospital but has moved to Detroit. When confronted [named Admissions Clerk#1] admitted to signing [named family member sister in law] name to change the RP. Family reported they had not given permission to do this."</p> <p>During an interview in the administrative suite on 9/12/12 at 12:30 PM, Admission Clerk #2 stated, "I told them they could not change RP without the original RP's permission." Admission Clerk #2 was asked who changed the RP. Admission Clerk #2 stated, "It was [named Admission Clerk #1]." Admission Clerk #2 was asked if Admission Clerk #1 was still employed. Admission Clerk #2 stated, "Yes, part time on call for us."</p> <p>Review of Resident #81's face sheet, with no date, documented the RP as a named cousin. A review of the current face sheet updated on 9/11/12 documented the RP as one of the named brothers.</p> <p>Review of Resident #81's HIPPA form documented, "...My Protected Health Information [PHI] may be disclosed to: and listed 2 [named] Brothers and 1 [named] Niece of Resident #81. This form was signed on 6/15/07 by the responsible party who was the resident's sister in law. The cousin's name was not included as someone who could receive information in regard to Resident #81.</p> <p>Medical record review revealed a "Consent for</p>	F 516			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 516	Continued From page 312 Restraint Use" that documented, "...The following alternative measures have been unsuccessfully tried prior to using this restraint: chair alert and lap buddy... I understand that [named Resident #81] may be at greater risk for falls and will risk the consequences of walking unassisted or of self-injury without the use of physical restraints... The type of restraint to be used is a soft belt applied when up in w/c [wheelchair]... I give [name of the facility] permission to physically restrain [named Resident #81]... Verification of Notification... on Feb. [February] 18, 2009 [named friend of Resident #81] was contacted by telephone and the above information was read to him/her." This was signed by a facility representative.	F 516			
F 518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility violated HIPPA by sharing medical information to a friend instead of the approved family members. The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on policy review, review of personnel records and interview, it was determined the facility failed to ensure 3 of 11 (Nurses #5, 12 and 13) were provided inservice training on disaster preparedness.	F 518			

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

PRINTED: 10/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 518	Continued From page 313 The findings included: Review of the facility's disaster preparedness policy documented, "...Our policy is to make sure all employees is inserviced on all disaster preparedness plans." Review of the personnel records for Nurses #5, 12 and 13, revealed no documentation of inservice training for disaster preparedness. During an interview at the 2nd Magoffin nurses station on 9/19/20 at 3:00 PM, Nurse #12 was asked about disaster preparedness. Nurse #12 stated, I do not know the facility's emergency policy. I only work on a day to day basis so I do not have to know the policies for the facility."	F 518			
F 520 SS=L	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the	F 520			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2012
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F 520	<p>Continued From page 314</p> <p>compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, pharmacy review, review of the Social Worker's job description, review of the nursing schedule, review of the time clock form, review of nursing agency invoices, contract review, review of the facility's census and condition report, medical record review, observation and interview, it was determined the facility's quality assessment (QA) and assurance committee failed to identify issues, develop and implement appropriate plans of action to correct identified quality deficiencies. The failure of the quality assurance and assessment committee to identify and address concerns resulted in immediate jeopardy which placed all of the 97 residents residing in the facility in immediate jeopardy (IJ). The facility was cited with IJ at F520 at a scope and severity of "L" following administrative review on 10/1/12. The facility was notified of this IJ per phone conversation on 10/3/12 at 8:45 AM and via fax on 10/3/12 at 9:31 AM. This IJ is considered present and ongoing.</p> <p>The findings included:</p> <p>1. During an interview in the Administrator's office on 9/20/12 at 1:40 PM the Administrator stated, "The QA committee meeting is conducted by the medical director and all department heads</p>	F 520			

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

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F 520	<p>Continued From page 315</p> <p>participate... the meetings are conducted monthly... issues recently addressed by the QA committee were falls, weights... and behaviors... once identified interventions are put in place, there is a monitoring process..."</p> <p>The interventions put in place were not effective as evidenced by:</p> <p>a. The facility failed to implement interventions after fall to prevent further falls. Refer to F323.</p> <p>b. The facility failed to ensure psychiatric services were provided to assess and provide the necessary care and services to address the behaviors of the resident displaying mental difficulty. Refer to F319.</p> <p>c. The facility failed to ensure nutritional status was assessed and develop approaches to prevent significant weight loss. Refer F325.</p> <p>2. The facility failed to ensure that safety measures were implemented to prevent entrapment hazards associated with the use of side rails for 4 of 5 (Residents #6, 13, 84 and 122) residents at risk for entrapment in siderails, which placed these four residents in immediate jeopardy (IJ). The facility failed to ensure a resident at risk for falls had interventions implemented after each fall to prevent further falls for 1 of 3 (Resident #23) sampled residents reviewed with falls, which placed Resident #23 in IJ. The facility failed to ensure the environment was free from accident hazards when 33 of 97 ambulatory residents could come and go unsupervised from their unit and enter through 4 of 4 doors to have access to 2nd McRee (a closed unit) and enter through 2 of 3 doors to 3rd Magoffin that allowed access to stairways and an elevator to enter the closed dark units of 2nd</p>	F 520			

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

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F 520	<p>Continued From page 316</p> <p>McRee and 3rd Magoffin. The facility failed to provide working smoke detectors for 4 of 68 (room 401, 403, 414 and 219) resident rooms. Refer F323.</p> <p>3. The facility failed to identify, assess, accurately assess, provide treatments and/or use preventive measures to prevent the development of avoidable pressure ulcers for 4 of 4 (Residents #54, 60, 74 and 82) sampled residents at risk of developing pressure ulcers of the 38 residents included in the stage 2 review. Failure of the facility to identify, assess, accurately assess and/or provide care and treatments resulted in an immediate jeopardy (IJ) when Resident #54 and #82 developed avoidable in-house acquired pressure ulcers and Resident #54 and 74's pressure ulcers deteriorated. Refer to F314.</p> <p>4. The facility failed to identify abuse; ensure allegations of abuse an injuries of unknown origin were reported immediately to the Administrator; allegations of abuse and injuries of unknown origin were thoroughly investigated; protect residents during the investigation and report an injury of an unknown origin and allegations of abuse to the state survey office placed Residents #47, 81, 14, 68, 82, and 116 in immediate jeopardy (IJ). Refer to F223, F224, F225 and F226.</p> <p>5. The facility failed to notify the physician of toxic, critical and abnormal laboratory results; that a swallowing study was not obtained and/or weight loss. The failure of the facility to timely notify the physician of critical and toxic laboratory results or that a swallowing study had not obtained when ordered resulted in the immediate</p>	F 520			

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F 520	Continued From page 317 jeopardy (IJ) to Resident #81 and Resident #23. Refer to F157. 6. The facility failed to promote care for residents in a manner that maintained or enhanced residents' dignity and respect for 4 of 38 (Residents #82, 6, 30 and 84) sampled residents. The facility failed to maintain dignity and respect of a resident when staff knowingly left her wet with urine during the evening and night shift, which resulted in the development of two new avoidable in house acquired stage II pressure ulcers which caused actual harm to Resident #82. Refer to F241. 7. The facility failed to ensure residents received the necessary care and services related to psychiatric services, dental or vision needs for 7 of 38 (Residents #116, 43, 60, 63, 68, 104, and 124) sampled residents. Failure to provide the necessary psychiatric services related to behaviors resulted in an Immediate Jeopardy (IJ) for Resident #116. Refer to F250 and F319. 8. The facility failed to provide housekeeping and effective maintenance services to maintain a sanitary, orderly and comfortable environment as evidenced by baseboards peeling from the wall and torn baseboards in bathrooms, scuff marks on walls, dust on personal fan blades, cracked and missing tiles, torn curtains, curtains with holes, missing hooks and curtains with brown stains, non working sink faucets, leaking faucets, non working air condition (AC) units with broken panels and missing dials, non working over bed lights, window curtains with torn hems, wet, dirty and brown stain towels in a sink on 3 of 3 (1st Magoffin, 2nd Magoffin and 1st McRee) units The	F 520			

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F 520	<p>Continued From page 318</p> <p>facility's failure to provide effective maintenance and housekeeping services to maintain a sanitary, orderly and comfortable environment resulted in substandard quality of care. Refer to F253.</p> <p>9. The facility failed to ensure bed linens were clean and in good condition on 3 of 3 (1st McRee, 1st Magoffin and 2nd Magoffin) units. Refer to F254.</p> <p>10. The facility failed to provide the necessary care and services to attain or maintain the highest practicable well-being by not following physician orders for obtaining laboratory (lab) tests, a swallowing study, providing treatments, administering medications, conducting a 3 day calorie count or timely notifications of lab results to the physician for 7 of 31 (Residents #81, 23, 28, 43, 84, 104, and 124) sampled residents of the 38 residents included in the stage 2 review. The failure of the facility to obtain laboratory tests and a swallowing study, provide treatments and notify the physician of abnormal lab results timely resulted in the immediate jeopardy (IJ) to Resident #81. The failure of the facility to obtain lab tests as ordered resulted in the immediate jeopardy of Residents #23. Refer to F309.</p> <p>11. The facility failed to ensure care plan interventions were followed for laboratory, dental, pressure ulcer, nutrition, rehabilitation, activities of daily living (ADL), accident prevention, restraints, unnecessary medications, range of motion (ROM), vision and/or falls for 12 of 31 (Residents #23, 81, 82, 74, 21, 28, 43, 63, 84, 104, 118 and 124) sampled residents of the 38 residents included in the stage 2 review. The</p>	F 520			

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F 520	<p>Continued From page 319</p> <p>facility failed to follow care plan interventions for fall preventive program; obtain, monitor and report abnormal laboratory levels as ordered, and perform wound care and ADL care as ordered placed Residents #23, 81, 82 and 74 in immediate jeopardy. Refer F282.</p> <p>12. The facility failed to ensure there was sufficient and competent nursing staff on 3 of 3 (1st McRee, 1st Magoffin and 2nd Magoffin units) nursing units to ensure residents were provided with the necessary care and services to meet their highest level of well-being. The facility failed to ensure adequate and competent nursing staff as evidenced by 4 of 6 (Nurses #2, 6, 7 and 9) nurses observed administering medications had a medication error rate 15.517 percent (%). The facility failed to ensure an adequate and competent nursing staff as evidenced by expired medications were available for use and having incorrect narcotic counts in 3 of 8 (1st McRee medication cart, 1st Magoffin West medication cart and 1st Magoffin medication room) medication storage areas. The facility failed to ensure adequate and competent nursing assessed, identified, and provided treatments for pressure ulcers for Residents #54, 60, 74, and 82. The failure of the facility to maintain an adequate and competent nursing staff resulted in immediate jeopardy (IJ) for all residents residing in the facility. Refer to F353.</p> <p>13. The facility failed to ensure there was a Registered Nurse (RN) that worked at least 8 consecutive hours a day, 7 days a week. Refer to F354.</p> <p>14. The facility failed to ensure that 2 of 31</p>	F 520			

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F 520	<p>Continued From page 320</p> <p>(Residents #101 and 124) sampled residents of the 38 included in the stage 2 review received nutritional management to assess and develop approaches to maintain the resident's nutritional status. The failure to provide nutritional intervention for residents with significant weight loss resulted in actual harm for Residents #101 and 124. Refer to F325</p> <p>15. The facility failed to ensure a Registered Dietitian (RD) assessed and implemented interventions that addressed nutritionally compromised residents with unplanned significant weight loss which resulted in actual harm for 2 of 38 (Residents #101 and 124) sampled residents included in the stage 2 review. Refer to F361.</p> <p>16. The facility failed to ensure the physician was promptly notified of toxic and critical laboratory tests results and failed to notify the physician when laboratory tests were not obtained as ordered for 2 of 38 (Residents #81 and 23) sampled residents included in the stage 2 review. The failure of the facility to promptly notify the physician of toxic and critical laboratory (lab) tests results and notify the physician when laboratory tests were not obtained as ordered resulted in the Immediate Jeopardy to Resident #81 and #23. Refer to F502 and F505.</p> <p>17. The facility failed to ensure the Medical Director assisted the facility with identifying, evaluating, and addressing clinical concerns, coordinate the medical care and provide clinical guidance and oversight regarding the implementation of resident care policies and procedures that reflect the current standards of</p>	F 520			

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F 520	Continued From page 321 practice for the 97 residents residing in the facility. The failure of the facility to ensure the Medical Director assisted with addressing clinical concerns, and provided guidance regarding resident care placed the 97 residents residing in the facility in immediate jeopardy (IJ). Refer F501.	F 520			