

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number: 445125
 (Y2) Multiple Construction: A. Building, B. Wing
 (Y3) Date of Revisit: 10/4/2011

Name of Facility: AMERICARE HEALTH AND REHABILITATION CENTER
 Street Address, City, State, Zip Code: 3391 OLD GETWELL RD, MEMPHIS, TN 38118

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 09/30/2011	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 09/30/2011	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 09/30/2011
ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 09/30/2011	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By: *SE* Reviewed By: *P14W02* Date: *10/6/11* Signature of Surveyor: *Sandra Jordan P14W02* Date: *10/4/11*
 State Agency: *Bondurant*
 Reviewed By: _____ Reviewed By: _____ Date: _____ Signature of Surveyor: _____ Date: _____
 CMS RO
 Followup to Survey Completed on: 9/8/2011
 Check for any Uncorrected Deficiencies, Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

SEP 25 2011 PRINTED: 09/12/2011
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 C 09/08/2011
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F 241 SS=D 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:
Intakes: TN00028601

Based on policy review, review of a disciplinary action form, review of an alleged abuse investigation, medical record review and interview, it was determined the facility failed to ensure a resident was spoken to respectfully without the use of profanity for 1 of 24 (Resident #1) sampled residents.

The findings included:
Review of the facility's "ABUSE" policy documented, "...It shall be the policy of [Named Facility] to ensure that all of its residents receive... care that is free from verbal ...1. Verbal Abuse: Any use of oral, written or gestured language that includes derogatory terms to the resident..."

Medical record review for Resident #1 documented an admission date of 1/24/02 with diagnoses of Diabetes Mellitus, Peripheral Vascular Disease, Asthmatic Bronchitis, Seizures, Psychosis, Schizoaffective Disorder, Anxiety and Depression.

Review of a "Disciplinary Action Form" dated 3/22/11 documented, "...DESCRIBE THE

F 241 F 241

The facility will promote care for residents in a manner and in an environment that maintains each resident's dignity and respect. The facility will ensure that all residents are spoken to respectfully, without the use of profanity even when employees are spoken to in a very abusive manner.

All staff members will be in-serviced on abuse, paying particular attention to verbal abuse to ensure that all residents are spoken to respectfully without the use of profanity. Staff will be required to sign a statement declaring their understanding of the content and the results of violating the abuse guidelines.

To protect other residents in similar situations all residents will receive a behavioral assessment. The behavior assessment will be used to identify residents with defined behavioral traits and those who exhibit behaviors that create conflict between resident and staff. The facility will relocate residents identified with behavioral issues to the appropriate unit. All staff will participate in specially designed in-services on how to deal with residents who exhibit adverse behaviors.

The facility will relocate residents identified with behavior issues to the appropriate unit.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Robert L. ...* TITLE: *Administrator* (X6) DATE: *9-23-11*

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 241	Continued From page 1 INCIDENT COMPLETELY... Resident [#1] complained that employee [Certified Nursing Assistant (CNA) #1] was verbally abusive to her today..." Review of an alleged abuse investigation conducted by the Director of Nursing (DON) documented, "On March 22, 2011 a resident [#1] ...reported to me that an employee [certified nursing assistant (CNA) #1] ...had cursed her [Resident #1] out... [named Resident #1] stated that [named CNA #1] called her "a bitch"... [CNA #1] became defensive stating... She [Resident #1] started cursing me [CNA #1] first... I [CNA #1] did tell her to 'take your ass back to your floor'..." During an interview in the DON's office on 9/8/11 at 3:45 PM, the DON was asked if the verbal abuse investigated on 3/22/11 had been reported to the state. The DON stated, "No."	F 241	The charge nurse on each unit for each shift , will observe staff interaction with residents. The charge nurse will complete the <u>Behavior Observation</u> form based on observations. These reports will be reviewed by the Behavior Committee chaired by the Psychiatrist bi-weekly for one (1) month and monthly thereafter for three (3) months and then as warranted. Quality Assurance Committee (QAC) will review summary reports quarterly.	9/30/2011	
F 280 SS=D	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	F 280	F 280 Care Plans will be revised for interventions to address behavior, restraints and/or emergency bleeding from dialysis access. The identified individual care plans have been revised to address proper interventions. Completion date 9/15/2011. Current dialysis residents, residents with restraints, and residents with behavioral issues care plans will be reviewed and revised to reflect their present status.		

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F 280 Continued From page 2
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 review of a facility memorandum, medical record review, observation and interview, it was determined the facility failed to revise the care plan for interventions to address behaviors, restraints and/or emergency bleeding from the dialysis shunt access for 3 of 24 (Residents #1, 5 and 20) sampled residents.

The findings included:

1. Review of a facility memorandum dated 6/15/11 documented, "...Please be advised that [Resident #1], is NOT to be off her unit... is allowed to attend any event... but must return to her unit immediately following... evening event... be on her unit/in her room, for the remainder of the night..."

Medical record review for Resident #1 documented an admission date 1/24/02 and a readmission date of 5/20/10 with diagnoses of Diabetes Mellitus, Peripheral Vascular Disease, Asthmatic Bronchitis, Seizures, Psychosis, Schizo affective Disorder, Anxiety and Depression. The care plan dated 6/8/11 and updated 8/31/11 did not address interventions from the memorandum related to behaviors.

During an interview in the Administrator's office

F 280 An audit of all resident's charts will be completed to insure proper care planning. The Care Plan Coordinator will review all new admissions within 24 hours of admission for dialysis, restraints, and behavior issues, utilizing the RESIDENT DIALYSIS, BEHAVIORAL AUDIT TOOL and initiate the appropriate care plan.

Findings will be reviewed by the Quality Care Committee (QCC) bi-weekly for one (1) month, monthly for three (3) months, and quarterly thereafter at the regular Quality Assurance Meeting

9/30/11

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F 280 Continued From page 3
on 9/8/11 at 2:04 PM, while discussing interventions for Resident #1's behaviors the Director of Nursing (DON) stated, "...was discussing housing placement and she hit her boyfriend [named boyfriend] and knocked him out of the chair..." The Administrator was asked what interventions were put in place to prevent this behavior from happening again. The Administrator stated, "...restricted her to protect other residents... She could go to activities, lunch and dinner in the dining room, smoke breaks and then she had to go back to her floor..."

F 280

During an interview in the DON's office on 9/8/11 at 3:05 PM, the DON was asked if the interventions to restrict Resident #1's movement within the facility was on the care plan. The DON stated, "...I don't see it... it truly should have been on there..."

2. Medical record review for Resident #5 documented an admission date of 2/16/06 with diagnoses of Hypertension, Anemia, and Senile Dementia. Review of the physician's recertification orders dated 8/31/11 documented, no orders for the use of a soft belt restraint. Review of the care plan updated 7/12/11 documented, "...Resident REQUIRES LAP BUDDY RESTRAINT... 4. Use Soft belt when in bed and when up in chair..." The care plan was not updated to reflect that the soft belt restraint was no longer in use.

Observations in the Resident #5's room on 9/6/11 at 10:15 AM and 12:24 AM and on 9/8/11 at 9:15 AM, revealed Resident #5 in bed with no soft belt restraint on.

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F 280 Continued From page 4 F 280

Observations in the Resident #5's room on 9/7/11 at 1:47 PM revealed Resident #5 sitting in a chair with no soft belt restraint on.

During an interview at the Magoffin first floor nurses' station on 9/7/11 at 1:47 PM, Certified Nursing Assistant #1 stated, "She [Resident #5] doesn't have a soft belt restraint; we changed to a lap buddy... around March."

During an interview in front of the DON's office on 9/8/11 at 9:05 AM, Nurse #5 stated, "...[Resident #5] had a soft belt restraint originally... and that was changed to a lap buddy in 2008..."

3. Medical record review for Resident #20 documented an admission date of 2/24/11 and a readmission date of 3/3/11 with diagnoses of End Stage Renal Disease, Congestive Heart Failure and Dementia. Review of a physician's order dated 4/8/11 documented, "...Dialysis Tu [Tuesday] - Th [Thursday] - Sat [Saturday]..." Review of the care plan dated 3/9/11 and updated on 9/1/11 documented, "...Monitor for bleeding at vas [vascular] cath [catheter] site..." The care plan did not address measures to be used for emergency bleeding from the shunt access site.

Observations in Resident #20's room on 9/8/11 at 10:00 AM, revealed Resident #20's shunt access site was in the right subclavian area.

During an interview in the Nurse #4's office on 9/8/11 at 10:26 AM, Nurse #4 confirmed that the care plan did not address measures to be used for emergency bleeding from the shunt access site.

F 309 483.25 PROVIDE CARE/SERVICES FOR F 309

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F 309 Continued From page 5
SS=D 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 accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation and interview, it was determined that the facility failed to follow a physician's orders for feeding a resident for 1 of 24 (Resident #5) sampled residents.

The findings included:

Medical record review for Resident #5 documented an admission date of 2/16/06 with diagnoses of Anemia, Hypertension and Senile Dementia. Review of the physician's recertification orders dated 8/31/11 documented, "...IS NOON FEEDER, RESTORATIVE DINING FOR BREAKFAST & [and] DINNER..."

Observations in Resident #5's room on 9/6/11 at 12:25 PM, revealed Resident #5 eating her noon meal. Resident #5 was feeding herself and was by herself. During the course of the meal, CNA #3 was in and out of the room on two different occasions, but did not remain with Resident #5.

During an interview in the Magoffin first floor nurses' station on 9/8/11 at 9:05 AM, Certified

F 309 F 309

The facility will follow physician orders for feeding a resident.

The resident involved in the deficient practice was re-evaluated for the appropriate eating program.

All charts will be audited to assure that physician orders are being followed for feeding a resident.

The Dietary and Nursing Department will compare weekly printouts of resident meal locations (where meals are served) to assure that all residents are in the appropriate area for meals and physician orders are followed.

Any variance will be reviewed by Nursing/Dietary weekly for one (1) month and randomly there after.

9/30/2011

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F 309 Continued From page 6
Nursing Assistant (CNA) #2 stated, "...[Resident #5] is a feeder. She feeds herself, but pockets food and can choke so we monitor her while she eats..." CNA #2 was asked to explain what she meant by "monitor". CNA #2 stated, "We [staff] stay with her while she eats..."

F 309

F 323 483.25(h) FREE OF ACCIDENT
SS=D HAZARDS/SUPERVISION/DEVICES

F 323 F 323

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.

The facility understands the importance of maintaining an environment free of accident hazards and that each resident receives adequate assistive devices to prevent accidents

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 investigate a fall occurrence and failed to prevent a fall for 2 of 8 (Residents #1 and 6) sampled residents with falls and failed to ensure that 15 of the facility's 76 wheelchairs were in good repair to prevent accidents/injuries.

Incident reporting policy will be revised to state that all falls – witnessed, un-witnessed and reported will have an incident filed and a follow-up investigation.

All staff will be in-serviced on the revised policy.

Staff will be in-serviced on proper positioning and proper adjustment of siderails after meals and care.

The findings included:

1. Review of the facility's "FALLING LEAVES PROGRAM" policy documented, "...PURPOSE: To identify residents at risk and provide interventions to prevent and minimize injuries that result from falls... The Fall Management Program will include the following: 1. Incident/Accident Report... Siderails used appropriately as assistive tool... Guidelines Complete an accident/incident

Replacement parts for the wheelchairs was ordered 9/7/2011 and replaced on 9/14/11. All wheelchairs are pressure washed quarterly and the condition of the wheelchairs evaluated at that time by the Building Support Manager. The Safety Committee will review the status of the repairing of the wheelchairs monthly for three months and quarterly thereafter.

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F 323 Continued From page 7 report..."

F 323

2. Medical record review for Resident #1 documented an admission date of 1/24/02 with diagnoses of Diabetes Mellitus, Peripheral Vascular Disease, Asthmatic Bronchitis, Seizures, Psychosis, Schizo affective Disorder, Psychosis, Anxiety and Depression. Review of a nurses note dated 6/6/11 documented, "...Res. [resident] c/o [complains of] pain to (L) [left] lower leg. Res. stated she fell on 6/5/11 getting out of bed to go to the restroom..." There was no documentation of an investigation of the fall occurrence nor of an incident/accident report being completed.

During an interview in the Director of Nursing's (DON) office on 9/8/11 at 3:05 PM, the DON was asked about her expectations for fall investigation and documentation for witnessed and/or unwitnessed falls. The DON stated, "...they're [nursing-staff] supposed to fill out an incident report..." The DON was asked if there was an incident report completed for the fall that occurred on 6/6/11. The DON stated, "I did not find an incident report..."

3. Medical record review for Resident #6 documented an admission date of 4/17/19 with diagnoses of Cerebrovascular Disease, Hypertension, Convulsions and Blindness in both eyes. Review of the physician's orders dated 8/8/11 documented, "...SR [side rails] UP X [times] 2..." Review of the "SIDE RAIL RATIONALE SCREEN" dated 10/20/09 documented "...Side rails are indicated and serve as enablers to promote independence..." Review of the nurses notes dated 8/10/11 documented,

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F 323 Continued From page 8 F 323

"...Received rpt [report] from staff that res sustained fall from bed..." Review of the facility's internal investigation of the fall documented, "...Found in floor beside bed [no injuries]... SR [symbol for down]..."

During an interview in Resident #6's room on 9/8/11 at 1:40 PM, Resident #6 was asked about the fall. Resident #6 stated, "They [staff] had forgotten to put the rail back up... I'm blind..."

4. Observations during a random tour of the facility on 9/7/11 AM starting at 10:15 AM, revealed 15 of the facility's 76 wheelchairs had arm rests that were either torn or absent.

During an interview outside of the laundry room on 9/8/2011 at 10:45 AM, the building support manager confirmed 15 of the facility's 76 wheelchairs had arm rests either torn or absent. The building support manager stated, "...Need a ledger..."