

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

PRINTED: 09/12/2011
FORM APPROVED
OMB NO. 0938-0381

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 09/08/2011
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 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4)
SS=D INVESTIGATE/REPORT
ALLEGATIONS/INDIVIDUALS

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.

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).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

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.

F 225 F 225

The facility will ensure that all residents are spoken to respectfully without the use of profanity.

Corrective action will include well defined in-service programs for ALL staff members with emphasis on the different types of abuse, with particular attention to examples of verbal abuse. Staff will be required to attend scheduled in-services and sign a statement declaring their understanding of the content and the results of violating the abuse guidelines. Allegations will be reported to the state survey and certification agency.

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.

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

Robert L. [Signature]

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 225 Continued From page 1

This REQUIREMENT is not met as evidenced by:
Based on policy review, review of a disciplinary action form, review of an alleged abuse investigations, medical record review and interview, it was determined the facility failed to report an allegation of verbal and physical abuse to the state survey and certification agency for 2 of 24 (Residents #1 and 23) sampled residents.

The findings included:

1. 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, 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 resident(s) regardless of their age, ability, to comprehend or disability... 3. Physical Abuse: Behavior that includes, hitting, slapping, pinching, use of unnecessary restraints to subdue a resident. Physical abuse may also included controlling behavior through corporal punishment... REPORTING THE INCIDENT... 8. Report all of the incidents of suspected or alleged resident abuse to the State Department of Health..."
2. Medical record review for Resident #1 documented an admission date of 1/24/02 with diagnoses of Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Asthmatic Bronchitis, Schizo affective Disorder, Psychosis, Osteoarthritis and Peripheral Vascular Disease.

F 225

The charge nurse on each unit for each shift, will observe staff interaction with residents. The charge nurse for each unit will complete the Behavior Observation form. Reports will be reviewed by the Quality Care Committee (QCC) bi-weekly for one (1) month and monthly thereafter for three (3) months. Then as warranted. Quality Assurance Committee (QAC) will review summary reports quarterly.

9/30/2011

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F 226 Continued From page 2 F 225

Review of a "Disciplinary Action Form" dated 3/22/11 documented, "...DESCRIBE THE INCIDENT COMPLETELY... Resident [#1] complained that employee was verbally abusive to her today..."

Review of the 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."

3. Medical record review for Resident #23 documented an admission date of 3/4/10 with diagnoses of Diabetes Mellitus, Hypertension, Senile Dementia, Convulsions, Paraplegia, Thyroid Disease, Peripheral Vascular Disease, Gastroesophageal Reflux Disease, Cerebrovascular Accident and Constipation.

During a review of Sub-task 5G-Abuse Prohibition Review, the Administrator provided one allegation of verbal and physical abuse that the facility had investigated since the last survey. Review of the facility's "INVESTIGATION OF ALLEGED physical abuse - verbal abuse" of Resident #23 documented, "...Date Investigated 6/29/11... pt

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F 225 Continued From page 3

[patient] stated ...the CNA [Certified Nursing Assistant (would not identify the CNA)] cursed him, referring to him as "nasty" and "funky ass" ... [Resident #23] says the CNA hit him on his left knee a couple of times... hit him with her hand on the left side of his face... hit him on his back... [Resident #23] states this CNA has hit him before..." Resident #23 would not identify the CNA.

F 225

During an interview in Resident #23's room on 9/8/11 at 11:35 AM, Resident #23 stated, "...well, I've been hit before in the face... they [staff] said I didn't want to get up... it didn't hurt too bad... they [staff] came back and said I'm sorry just want to leave it at that... don't want them to lose their jobs... just leave it at that..."

During an interview in the Administrator's office on 9/8/11 at 9:00 AM, the Administrator confirmed he had not reported this incident to the state survey and certification agency as required.

F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

F 241 F 241

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.

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.

This REQUIREMENT is not met as evidenced by:
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

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F 241 Continued From page 4
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 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

F 241 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.

The charge nurse on each unit for each shift, will observe staff interaction with residents. The charge nurse will complete the Behavior Observation 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.

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F 241 Continued From page 5
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

9/30/2011

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP
SS=D

F 280 F 280

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.

Care Plans will be revised for interventions to address behavior, restraints and/or emergency bleeding from dialysis access.

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.

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.

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.

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.

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 Quarterly Assurance Meeting

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F 280 Continued From page 6
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, Schizoaffective 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 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..."

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

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F 280 Continued From page 7
stated, "...I don't see it... it truly should have been on there..."

F 280

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.

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

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F 280 Continued From page 8
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.

F 280

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
SS=D HIGHEST WELL BEING

F 309

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

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F 309	Continued From page 9 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 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 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.	9/30/11	
F 314	483.25(c) TREATMENT/SVCS TO SS=D 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	F 314 F 314	The facility understands the importance of wound care documentation and will accurately assess, document and provide treatment of pressure ulcers and will follow physician orders for daily wound care.		

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F 314 Continued From page 10
prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:

Based on review of the "National Pressure Ulcer Advisory Panel (NPUAP) Pressure Ulcer Prevention QUICK REFERENCE GUIDE", medical record review, observation and interview, it was determined the facility failed to assess, document and provide treatment of a pressure ulcer and failed to accurately assess a pressure ulcer for 2 of 10 (Residents #8 and 14) sampled residents with pressure ulcers.

The findings included:

1. Review of the "National Pressure Ulcer QUICK REFERENCE GUIDE" documented, "...Unstageable... Stable (dry, adherent, intact without erythema or fluctuance [change]) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed..."
2. Medical record review for Resident #8 documented an admission date of 10/2/07 with diagnoses of Peripheral Vascular Disease, Left Lower Extremity Deep Vein Thrombosis, Pulmonary Nodule, Nutritional Deficit and Multiple Pressure Ulcers. Review of a physician's order dated 5/5/11 documented, "...Clean right & [and] left upper buttocks c [with] NS [Normal Saline], pat dry & apply santyl & cover c 4x [by] 4s & dry dressing Q [every] D [Day]..." Review of the treatment record dated 5/5/11 through (-) 5/31/11 revealed no documentation of wound care on 5/6, 5/7, 5/8, 5/14, 5/15, 5/16, 5/18, 5/19, 5/21, 5/22, 5/23, 5/25, 5/26 and 5/28, 2011. The facility did

F 314 Resident # 8 who was involved in the afore mentioned deficiency, was re-assessed by the Wound Care Specialist on 5/31/2011. Assessment and documentation thereafter on the resident's wound was performed per physician orders until the wound healed. Review of resident # 14 medical record revealed documentation of the (R) heel on 8/1/11, 8/11/11, 8/23/11, and 8/31/11; area healed 9/8/11. (L) Left heel on 8/1/11, 8/11/11, 8/23/11, 8/31/11, and 9/8/11. (see attached)

The facility will quarterly in-service all Nurses involved in wound care and the Clinical Excellence Nurse on the policy of weekly documentation.

An audit will be completed on all residents with wounds to assure that physician orders are followed for treatments and documentation is completed weekly per facility protocol.

The Certified Wound Care Specialist will audit all treatment administration records to assure that treatments are documented for the previous week and the weekly documentation is complete. This will be done weekly for one (1) month and monthly thereafter.

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

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F 314	Continued From page 11 not follow the physician's order for daily wound care.	F 314		
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Review of the facility's "TREATMENT NURSE IN-HOUSE SKIN ASSESSMENT" dated 5/5/11 documented, "...Stage II to left buttocks & right buttocks..." The facility's "TREATMENT NURSE IN-HOUSE SKIN ASSESSMENT" dated 5/31/11 documented, "...Left buttocks Stage III..." There was no documentation of wound assessment from 5/5-31/11.

During an interview at the 2nd Magoffin Nurses' station on 9/7/11 at 1:00 PM, Nurse #6 was asked if there was any documentation of wound care or measurements in Resident #8's record for 5/5-31/11. Nurse #6 stated "...No..."

During an interview in the DON office on 9/8/11 at 8:50 AM, the DON was asked if the treatment had been performed as ordered. The DON stated, "...It wasn't daily like it should have been..."

During an interview in the DON's office on 9/8/11 at 3:15 PM, the DON was asked who performs wound care in the absence of Nurse #6. The DON stated "...the weekend nurse or if there is an extra Licensed Practical Nurse she does the treatment..." The DON was asked where would the treatment be documented. The DON stated "...They [nurses] document their treatment on the treatment record..."

3. Medical record review for Resident #14 documented an admission date of 1/21/11 with diagnoses of Dementia with Behavioral Disturbance, Schizophrenia, Hypertension and

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F 314 Continued From page 12

F 314

Diabetes. Review of the "TREATMENT NURSE IN-HOUSE SKIN ASSESSMENT" dated 7/31/11 documented, "...Resident c [with] unstageable ulcers to bil. [bilateral] heels. Right medial heel size 6 cm [centimeters] x 6 cm c 0 [without] opening wound bed black hard necrotic tissue... Left lateral heel unstageable ulcer size 7 cm x 8 cm wound bed c black hard necrotic tissue c 0 drainage & 0 odor noted..." Review of the "WEEKLY PRESSURE ULCER HEALING RECORD" dated 8/1/11 documented, "...WOUND BED... Black/Brown (eschar)..." There was no further documentation of the wound.

Observations in Resident #14's room on 9/8/11 at 11:30 AM, revealed the right heel to have intact natural colored skin with dark brown dry flakes of loose skin at the edges of the 6 cm x 6 cm wound area. The left heel had very dry peeling dark brown loose skin surrounding the outer edges of the 7 cm x 8 cm wound area and revealed a 2.5 cm x 1 cm wound with the wound bed covered in a hard, yellow, stringy substance.

During an interview in the Administrator's office on 9/8/11 at 11:20 AM, the wound nurse was asked about the description of the wound bed. The wound nurse stated, "It looked more like a blood blister where he rubbed his heels on his shoes."

During an interview in Resident # 14's room on 9/8/11 at 11:30 AM, Nurse #6 was asked about the appearance of the wounds. Nurse #6 stated that both areas had been covered with dark brown to black dry skin and "...the cap [dry skin covering the wounds] must have just come off..."

F 323 483.25(h) FREE OF ACCIDENT

F 323 F 323

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F 323 Continued From page 13
SS=E 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 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.

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 report..."

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,

F 323 The facility understands the importance of maintaining an environment free of accident hazards and that each resident receives adequate assistive devices to prevent accidents

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.

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 14

F 323

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, "...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

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F 323	Continued From page 15 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..."	F 323	
F 332 SS=D	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 review of the "MED-PASS COMMON INSULINS" provided by the American Consultant Pharmacists, policy review, medical record review, observation and interview, it was determined the facility failed to ensure 2 of 9 (Nurses #1 and 2) nurses administered medications with a medication error rate less than 5 percent (%). A total of 3 errors were observed out of 45 opportunities for error, resulting in a medication error rate of 6.66%. The findings included:	F 332 F 332	The facility will ensure that the facility is free of medication error rates of five percent or greater. All nurses, especially those involved in the deficient practice, have been in-serviced by the Pharmacy Consultant on medication via enteral feedings and insulin administration as it relates to meal times. All nurses will be checked off weekly for one month on medication pass paying particular attention to medication pass via enteral tube feeding and insulin administration as it relates to meal times.

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F 332 Continued From page 16
1. Review of the "MED-PASS COMMON INSULINS: Pharmacokinetics, Compatibility, and Properties" provided by the American Society of Consultant Pharmacist for typical dosing administration of insulin related to meals documented, "...Novolin R [regular] ... ONSET (In Hours, Unless Noted)... 0.5- [to] 1... TYPICAL DOSING / COMMENTS... 30 MINUTES BEFORE MEALS..."

F 332 The medication administration policy for administering meds per enteral tube will be revised and all licensed staff in-serviced on the enteral policy

The medication error rate will be discussed monthly in the Quarterly Care Meeting and quarterly in the Quarterly Assurance Meeting.

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Medical record review for Random Resident (RR) #1 documented an admission date of 7/15/11 with diagnoses of Hypoglycemia, Seizure Disorder, Leukocytosis, Deep Vein Thrombosis, Diabetes, Hypertension, and Dementia. Review of the physician's orders dated 9/6/11 documented, "...NOVOLIN R 100U [units] / [per] ML [milliliters] VIAL SS [sliding scale]-SQ [subcutaneous] ...251-300= [amount of insulin to be administered] 8U..."

Observations in RR #1's room on 9/6/11 at 11:56 AM, Nurse #1 administered 8 units of Novolin R insulin SQ to RR #1. RR #1 did not receive his lunch tray until 12:41 PM. The administration of the insulin 45 minutes before lunch was served resulted in medication error #1.

During an interview in the Director of Nursing's (DON) office on 9/8/11 at 12:10 PM, the DON was asked how soon should a resident receive a meal tray after receiving regular insulin. The DON stated, "[The resident] should eat within 30 minutes."

2. Review of the facility's "ENTERAL TUBE MEDICATION ADMINISTRATION" policy documented, "...The medication cup is rinsed with

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F 332 Continued From page 17
water to get all the medication from the cup..."

F 332

Medical record review for Resident #9 documented an admission date of 6/1/11 with diagnoses of Dehydration, Hypertension, Cerebrovascular Accident, Encephalopathy, Percutaneous Endoscopy Gastrostomy (PEG) Tube, Dysphagia and Blindness. Review of the physician's orders dated 7/6/11 documented, "...VITAMIN C 500 MG [milligrams] TABLET TAKE 1 TABLET PER PEG TUBE 2 TIMES DAILY... ZINC SULFATE 220 MG CAPSULE TAKE 1 CAPSULE PER TUBE 2 TIMES DAILY..."

Observations in Resident #5's room on 9/6/11 at 4:15 PM, revealed Nurse #2 administered Vitamin C 500 mg and Zinc Sulfate 220 mg per PEG tube. Nurse #2 left a moderate amount of crushed medication in the medication cup. Failure to administer the complete dosage of the medications resulted in medication error #2 and #3.

During an interview in Resident #2's room on 9/6/11 at 4:20 PM, Nurse #2 confirmed the medication cup contained a moderate amount of crushed medication.

F 333 483.25(m)(2) RESIDENTS FREE OF
SS=D SIGNIFICANT MED ERRORS

F 333 F 333

The facility must ensure that residents are free of any significant medication errors.

The facility will ensure that the facility is free of significant medication errors.

This REQUIREMENT is not met as evidenced by:
Based on review of the "MED-PASS COMMON

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F 333 Continued From page 18

"INSULINS" provided by the American Consultant Pharmacists, medical record review, observation and interview, it was determined the facility failed to ensure 1 of 9 (Nurse #1) nurses administered medications without a significant medication error. Nurse #1 failed to administer insulin within the proper time frame related to meals for Random Resident (RR) #1.

The findings included:

Review of the "MED-PASS COMMON INSULINS: Pharmacokinetics, Compatibility, and Properties" provided by the American Society of Consultant Pharmacist for typical dosing administration of insulin related to meals documented, "...Novolin R [regular] ... ONSET (In Hours, Unless Noted)... 0.5- [to] 1... TYPICAL DOSING / COMMENTS... 30 MINUTES BEFORE MEALS..."

Medical record review for Random Resident (RR) #1 documented an admission date of 7/15/11 with diagnoses of Hypoglycemia, Seizure Disorder, Leukocytosis, Deep Vein Thrombosis, Diabetes, Hypertension and Dementia. Review of the physician's orders dated 9/6/11 documented, "...NOVOLIN R 100U [units] / [per] ML [milliliters] VIAL SS [sliding scale]-SQ [subcutaneous] ...251-300= [amount of insulin to be administered] 8U..."

Observations in RR #1's room on 9/6/11 at 11:56 AM, Nurse #1 administered 8 units of Novolin R insulin SQ to RR #1. RR #1 did not receive his lunch tray until 12:41 PM. The administration of the insulin 45 minutes before lunch was served resulted in a significant medication error.

F 333 All nurses, especially those involved in the deficient practice, have been in-serviced by by the Pharmacy Consultant on insulin administration as it relates to meal times.

All nurses will be checked off weekly for one month, monthly for three months and randomly thereafter on medication pass paying particular attention to insulin administration as it relates to meal times.

The medication error rate will be discussed monthly in the Quality Care Meeting and quarterly in the Quality Assurance Meeting.

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F 333 Continued From page 19
During an interview in the Director of Nursing's (DON) office on 9/8/11 at 12:10 PM, the DON was asked how soon should a resident receive a meal tray after receiving regular insulin. The DON stated, "[The resident] should eat within 30 minutes."

F 333.

F 441 483.65 INFECTION CONTROL, PREVENT SS=D SPREAD, LINENS

F 441 F 441

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.

The facility will ensure that all nurses follow proper handwashing technique during medication pass.

- (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.

All licensed staff especially those involved in the deficient practice have been in-serviced by the Pharmacy Consultant on handwashing during medication pass.

- (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.

All nurses will be checked off weekly for one (1) month, monthly for three (3) months and quarterly thereafter on medication pass paying particular attention to handwashing.

The Quality Care Committee will review results of handwashing for compliance during med pass weekly for one (1) month, monthly for three (3) months then quarterly thereafter. Quality Assurance Committee will review results every three (3) months until compliance is met.

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F 441 Continued From page 20

F 441

(c) Linens

Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

Based on review of the "Long-Term Care Pocket Guide for Infection Control", policy review, observation and interview, it was determined the facility failed to ensure 2 of 9 (Nurses #1 and 3) nurses followed proper handwashing technique during medication pass.

The findings included:

1. Review of the "Long-Term Care Pocket Guide for Infection Control" (Section 2, Hand Hygiene) documented, "Handwashing is the single most important thing you can do to prevent the spread of infection... When wearing gloves, wash hands as soon as the gloves are removed... Germicidal handrubs are recommended only when you can't wash. You should adhere to the following handwashing advice ...Decontaminate hands after removing gloves... Turn off faucet with a clean, dry paper towel and throw the towel away..."
2. Review of the facility's "HANDWASHING" policy documented, "Policy... Handwashing before and after donning gloves is also required... Procedure... If the sink is not equipped with knee or foot controls, turn off the faucets by gripping them with a dry paper towel to avoid

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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 09/08/2011
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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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(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
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F 441 Continued From page 21
recontamination of your hands..."

F 441

3. Observations in Random Resident (RR) #1's room on 9/6/11 at 11:50 AM, revealed Nurse #1 obtained RR #1's blood sample for glucose testing, removed her gloves, disposed of used lancet in the sharps container and cleansed the glucometer. Nurse #1 then prepared insulin for RR #1. Nurse #1 did not wash her hands after removing the gloves.

4. Observations in RR #2's room during medication pass on 9/7/11 at 9:10 AM, Nurse #3 washed his hands and turned the faucet off bare-handed.

Observations in RR #3's room on 9/7/11 at 9:18 AM, Nurse #3 administered eye drops to RR #3. Nurse #3 washed his hands and turned the faucet off bare-handed.

5. During an interview in the Director of Nursing (DON) office on 9/8/11 at 12:10 PM, the DON was asked when should hands be washed when using gloves. The DON stated, "[Staff] should wash hands before they apply gloves and should wash after removing gloves." The DON confirmed the faucet should not be turned off with bare hands while washing hands.

F 469 483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM

F 469 F 469

The facility must maintain an effective pest control program so that the facility is free of pests and rodents.

The facility understands the maintenance of a clean, safe environment and work hard to ensure facility is clean, orderly and free of odor and is embarrassed that roaches were found in the building.

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

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			(X5) COMPLETION DATE

F 469 Continued From page 22
This REQUIREMENT is not met as evidenced by:
Based on observation and the group interview, it was determined the facility failed to have an effective pest control program as evidenced by the presence of roaches in 2 of 89 resident rooms (rooms 117 and 204) and 1 of 6 (2nd McRee hallway) hallways.

The findings included:

1. Observations in resident room 117 on 9/8/11 at 1:30 PM, revealed a roach crawling on the floor.
2. Observations in room 204 on 9/6/11 at 10:20 AM, revealed a roach crawling under the resident's bed.
3. Observations on 2nd McRee in the hall across from room 503 on 9/6/11 at 10:43 AM, revealed a roach on the wall. Observations on the 2nd McRee hallway on 9/6/11 at 10:45 AM, revealed a roach on the floor.
4. During the group interview in the small television room, on 9/6/11 at 3:00 PM, eleven alert and oriented residents confirmed they had seen roaches in the facility.

F 514 483.75(l)(1) RES
SS=D RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

F 469: The Pest Control contract with Rainbow was immediately terminated and a new pest control (Pest of TN Inc.) was hired on 9/4/11 to provide pest control services.

The Pest Control Policy will be revised to ensure that areas where food is present and where there is excessive clutter (resident's room, etc.) will have increased attention to the cleaning process.

This will be monitored by the Building Support Manager and Housekeeping Services daily for two weeks; weekly for two weeks and monthly thereafter to monitor effectiveness of the preventative pest control process.

9/30/2011

F 514 F 514

The facility failed to maintain complete and accurate medical records for physician orders.

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F 514 Continued From page 23

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to maintain complete and accurate medical records for physician's orders 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 orders dated 7/29/11 documented, "DC [discontinue] NCS [no concentrated sweets], NAS [no added salt] with chopped meats... Start Pureed NCS, NAS diet..." Review of the Physician's recertification orders dated 8/31/11 documented, "...NCS, NAS Diet W [with] / Chopped meats..."

During an interview at the Magoffin first floor nurses' station, on 9/7/11 at 12:20 PM, the Dietitian stated, "...[Resident #5] is on a puree diet..." The dietitian was shown the physician orders for a diet with chopped meats. The dietitian stated, "...That just wasn't carried over. I'll write a clarification order..."

F 514. Nurses will be in-serviced on the correct method of checking monthly recertifications.

Dietary will give a list of diets monthly to each unit to compare to the monthly recertifications and any variances will be corrected immediately.

9/30/2011