

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445411	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/16/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER APPLINGWOOD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1536 APPLING CARE LANE CORDOVA, TN 38018
--	--

(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 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, and interview, the facility failed to assess and document the reason for pain medications for 1 of 6 (Resident #89) sampled residents reviewed receiving pain medications.</p> <p>The findings included:</p> <p>The facility's "Pain Management" policy documented, "A definition for pain widely used in nursing is "Pain is whatever the experiencing person says it is, existing whenever he says it does." It is a major symptom in many medical conditions significantly interfering with a person's quality of life and general functioning. The phrase "Pain as the 5th Vital Sign ...Vital signs are assessed and taken seriously by healthcare professionals. We should also assess and treat pain with the same zeal..."</p> <p>Medical record review revealed Resident #89 was admitted to the facility on 3/11/15 and discharged on 6/6/15 with diagnoses of Acute Respiratory Failure, Muscle Weakness, Late Effect Cerebrovascular Accident, Congestive Heart Failure, Chronic Obstructive Bronchitis,</p>	F 309	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident will receive and the facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Corrective Action:</p> <ol style="list-style-type: none"> On 6/6/15 Resident #89 was discharged from the facility. Nurse management completed 100% audit on 8/14/15 of as needed pain medications for documented reason for administration. All licensed nurses were in-serviced on 7/17/15, by Regional Nurse Consultant on proper documentation of as needed pain medications. The DON and/or designee will monitor for compliance through review of weekly random audits for the next three months. Findings will be reported to the QA & A Committee, consisting of the Medical Director, Administrator, DON, ADON, Staffing Coordinator, MDS Coordinator, Dietary, Social, Activity Directors. If compliance is not met, licensed nurses will be re-in-serviced and audits will continue until compliance is met. <p>Completion date:</p>	8/16/2015
---------------	---	-------	---	-----------

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X8) DATE 8-14-15

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

RECEIVED

AUG 14 2015

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445411	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/16/2015
NAME OF PROVIDER OR SUPPLIER APPLINGWOOD HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1536 APPLING CARE LANE CORDOVA, TN 38018		
(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 309	<p>Continued From page 1</p> <p>Gastrostomy Status, Cachexia, Hypertension, Encephalopathy, Malnutrition, Atrial Fibrillation, Dementia, Dysphagia, Rheumatoid Arthritis, Cardiomyopathy, Aortic Stenosis, Debility, Pulmonary Embolism, Failure to Thrive, Malignant Neoplasm, and Insomnia.</p> <p>The 60 day Minimum Data Set (MDS) assessment with an assessment reference date of 5/6/15 documented a Brief Mental Status (BIMS) of 15, indicating the resident was cognitively intact, received scheduled pain medications in the last 5 days, as needed pain (PRN) medications were received in the last 5 days, no non-medication interventions were received the last 5 days, yes to pain in the last 5 days, experienced rare pain in the last 5 days, pain had not made it hard to sleep, had not limited day to day activities, and worst pain was a 2 on scale of 0 to (-) 10.</p> <p>The physician's orders dated 5/14/15 documented, "...LORTAB 5-325 mg [milligrams] (1) TABLET Enteral Tube... 1... bid [two times a day] prn..." The Medication Administration Record (MAR) for April 2015 and May 2015 documented Resident #89 received PRN Lortab on 4/1/15 times (x) 2, 4/2/15, 4/9/15, 4/11/15, 4/12/15, 4/16/15, 4/20/15 x 2, 4/23/15, 4/24/15 x 2, 4/25/15, 5/3/15, 5/4/15, 5/10/15, 5/12/15, and 5/18/15 but there was no reason for the administration documented on the MAR.</p> <p>The clinical notes dated 4/24/15 documented, "...Resident requested PRN pain medication after therapy..." There was no other documentation in the clinical notes for April 2015 or May 2015 of any reason the PRN pain medication doses were given. The "Patient Vital Sign Report"</p>	F 309			

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445411	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/16/2015
NAME OF PROVIDER OR SUPPLIER APPLINGWOOD HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1536 APPLING CARE LANE CORDOVA, TN 38018		
(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)	(X6) COMPLETION DATE	
F 309	Continued From page 2 documented on 4/26/15 and 4/27/15, a pain level of 6 (the resident did not receive PRN Lortab on these two days). This was the only documentation of pain on this report from 4/3/15 through (-)5/11/15. Interview with Registered Nurse (RN) #1 on 7/16/15 at 9:38 AM, in the sunroom, RN #1 was asked about the nurses' notes and assessments with no documentation of pain, and the MARS with documentation of PRN Lortab administered with no reason for giving this medication. RN #1 confirmed there should be documentation of the reason to give the PRN Lortab, and stated, "I don't know why she [Resident #89] was getting it [Lortab] then, I don't know why they [nurses] were doing that."	F 309			
F 323 SS=E	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 policy review, review of a facility fall investigation, medical record review, observation, and interview, the facility failed to ensure the environment was free of accident hazards related to falls and/or elopement for 3 of 7 (Residents #51, 59 and 92) sampled residents reviewed for falls and/or elopement; full sharps containers in 2	F 323	483.25(h) FREE OF ACCIDENT HAZARDS/ SUPERVISION/DEVICES The facility will ensure that the resident environment remains as free of accident hazards as is possible; and that each resident receives adequate supervision and assistance devices to prevent accidents. Corrective action: 1. (A) Resident #51 assessed for being at risk of elopement and a wanderguard was placed on the resident as of 4/14/15 by nurse management and on 7/17/15 resident #51 was reassessed and the wanderguard was removed. (B) Resident #59 was assessed for being at risk of elopement, on 4/17/15 by nurse management. As of 7/20/15 wanderguard remains in place. All exit doors checked and armed on 7/16/15 and 8/12/15. (C) Resident #92 discharged from the facility on 5/15/2015. (D) All falls/occurrences audited on 8/13/15 by the DON for investigations with appropriate statements attached for review by fall meeting committee with 72 hour follow up. (E) On 8/13/15 all over-filled sharps containers replaced as necessary by the ADON. (F) On 8/13/15 all resident areas and shower rooms were assessed for hazards, such as razors,		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445411	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/16/2015
NAME OF PROVIDER OR SUPPLIER APPLINGWOOD HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1536 APPLING CARE LANE CORDOVA, TN 38018		
(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 3 of 41 (Rooms 304 and 305) resident rooms; and an unsecured razor in 1 of 2 (100 hall spa) spas.</p> <p>The findings included:</p> <p>1. The facility's "Fall Risk/Fall Prevention Guidelines" policy documented, "...A Fall Risk Assessment... will be completed by a licensed nurse indicating the patient's risk factors: 1. Upon admission/readmission to the facility 2. After a fall 3. Significant change in medical status 4. Quarterly... Post Fall Management... Licensed Staff... A. Will complete the Nurse Event Note... C... update the Fall Risk Assessment Tool, gather statements from staff members... and/or other witnesses... E. Licensed nursing will complete follow-up monitoring documentation on each shift after each fall for 72 hours..."</p> <p>The facility's "Elopement Policy" documented, "...each patient will have an Elopement Risk Assessment completed upon admission / readmission, quarterly, and with a significant change instatus... patients that trigger 'Yes'... will be identified as being at risk for elopement... A wander guard device and/or other applicable intervention(s) will be implemented in order to reduce the patients risk for elopement..."</p> <p>2. Medical record review for Resident #51 revealed that Resident #51 was admitted to the facility on 9/26/14 with diagnoses of Bacterial Pneumonia, Diabetes Mellitus, Congestive Heart Failure, Cardiomegaly, Coronary Artery Disease, Hypertension Anemia, Rheumatoid Arthritis, Dementia, Hypothyroidism, Anxiety, Depression, Cataract, Chronic Kidney Disease.</p> <p>The significant change Minimum Data Set (MDS)</p>	F 323	<p>and removed accordingly by ADON.</p> <p>2. (A) On 8/13/15 Nurse management conducted facility rounds and ensured all wanderguards in place. (B) On 8/13/15 Nurse management conducted audit on residents for completed elopement risk assessment and all exit doors for being not being disarmed. (C) On 8/14/15 Nurse management conducted audit of fall investigations for necessary statements and 72 hour follow up. (D) On 8/14/15 Nurses management conducted audited of fall meetings with appropriate staff in attendance, as necessary. (E) On 8/13/15 Nurse management conducted rounds to replace all over-filled sharps containers in resident areas and shower rooms. (F) Nurse management conducted rounds on 8/13/15 in resident care areas and shower areas to ensure that hazards, such as razors, are not unsecured.</p> <p>3. All licensed nurses in-serviced by 7/21/15 and 8/14/15, on investigating, and obtaining statements, as needed for all fall occurrences, with 72 hour follow up as needed, conducting elopement risk assessments, apply/monitoring Wanderguards as necessary, by Regional Nurse Consultant. All staff was in-serviced on 7/21/15 and 8/14/15, by Regional Nurse Consultant and Administrator, regarding hazards being left unattended, sharps containers replaced when needed, doors not to be disarmed without staff attendance.</p> <p>4. Nursing Management will monitor for compliance by completing weekly random audits for three months. Findings will be reported to the QA & A Committee, consisting of the Medical Director, Administrator, DON, ADON, Staffing Coordinator, MDS Coordinator, Dietary, Social, & Activity Directors. If compliance is not met, licensed nurses and all staff will be re-in-serviced and audits will continue until compliance is met.</p> <p>Completion date:</p>	8/16/15	

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445411	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/16/2015
NAME OF PROVIDER OR SUPPLIER APPLINGWOOD HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1536 APPLING CARE LANE CORDOVA, TN 38018		
(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 4 with an Assessment Reference Date (ARD) 3/17/15 documented Brief Interview of Mental Status (BIMS) of 4 indicating severe impaired. There were no falls documented on this MDS. The quarterly MDS with an ARD 6/9/15 documented BIMS of 4 and documented 1 fall with no injury since admission.</p> <p>The care plan dated 3/18/15 documented, "...has exhibited Wandering Behavior. 6/10/15 wanderguard removed, she no longer wanders... Assess potential physical causes for wandering (need for toilet, water, food, pain relief)... Provide diversional activities (folding, rummaging box, packing/unpacking)... Redirect [named resident] behavior/activity when wandering is observed.. .Use wander guard/location monitor daily... Wanderguard to L [left] leg... Remove wanderguard... Provide orientation to facility layout and room as needed... Monitor resident's location to ensure safety... At Risk for Falls R/T [related to] Arthritis, s/e [side effects] cardiac ds [disease]... Fall 6/12/15 @ [at] 1000, no apparent injury. Intervention-Staff education on positioning in bed... Footware will fit properly and have non-skid soles... Keep areas free of obstructions to reduce the risk of falls or injury... Place call bell/light within easy reach... Provide reminders to use ambulation and transfer assist devices... Remind [named resident] to call for assistance before moving from bed-to-chair and from chair-to-bed..."</p> <p>The fall investigations for Resident #51's 2 falls documented, for the fall on 5/8/15, an "Interdisciplinary Team Occurrence Investigation Worksheet", an occurrence investigation statement, an occurrence investigation and 1 clinical note entry. The investigation for the fall on</p>	F 323			

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445411	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/16/2015
NAME OF PROVIDER OR SUPPLIER APPLINGWOOD HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1536 APPLING CARE LANE CORDOVA, TN 38018		
(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 5</p> <p>6/12/15 consisted of an "Interdisciplinary Team Occurrence Investigation Worksheet" and 1 nurse's event note dated 6/12/15.</p> <p>Interview with Licensed Practical Nurse (LPN) #3 on 7/15/15 at 5:19 PM, in the sunroom, when asked about the elopement incident with Resident #51. LPN #3 stated, "This happened at the end of my shift I was at the desk charting and overheard the CNA [certified nursing assistant #7] talking to another CNA [#8] and I heard them saying the [named Resident #51] had got out the front door. CNA #7 had gone out and retrieved the resident and brought her back in. I had seen her go sit in the lobby from time to time I had never seen her try to go outside before."</p> <p>Interview with CNA #7 on 7/15/15 at 6:08 PM, in the sunroom, CNA #7 was asked about Resident #51's incident when she walked out front door. CNA #7 stated, "A resident's family member was leaving and he came and got me and stated he thought a resident was outside. He went out with me and helped me get her in the chair. She left her wheelchair at the door and he held her steady while I pushed chair up to her. She wasn't a wanderer before that day. She always had family come see her and doesn't talk about going home. She was more mobile in her wc [wheelchair] then. No known attempts since then of trying to get out, she declined pretty rapidly. She had a lot of agitation and behaviors since her decline but did not before the incident."</p> <p>Interview with CNA #8 on 7/15/15 at 6:22 PM, in the sunroom, CNA #8 was asked about Resident #51's incident when she walked out front door. CNA #8 stated, "She was my patient. After dinner we put them in the hallway. I start putting other</p>	F 323			

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445411	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/16/2015
NAME OF PROVIDER OR SUPPLIER APPLINGWOOD HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1536 APPLING CARE LANE CORDOVA, TN 38018		
(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 6</p> <p>residents in the bed, but left her where I could keep an eye on her. But she was real quick. A family member of another resident came in and said that a resident was outside. [CNA #7] went out with him to get her and I went to the nurse [LPN #5] and said that [named Resident #51] needed a wanderguard. She didn't have one. She said she would let them know. The next day I notified the DON [Director of Nursing] that she [Resident #51] needed a wanderguard and they placed one on her leg that next day. When she was brought back in, she told me she was trying to get home. She often talked about going home. She would go to the door often and push the door but can't get out, usually after dinner. Sometimes we would take her out on the porch to sit. She was walking then and she could get around. She had went to sit outside [room] 117... I went to put 1 patient to bed and she had gone down 100 hall and out the front door. LPN #5 assessed the resident and took vitals when she was brought back to room. She started refusing dialysis a while after that and then started to decline. She still attempts to get out of bed, not too much agitated, just wants up. This occurrence happened between 6 to 7 PM. We do occurrence sheet for incidents and I asked LPN #5 if she wanted me to do one and she told me she would do it."</p> <p>Telephone interview with LPN #5 on 7/16/15 at 8:38 AM, LPN #5 was asked about Resident #51's incident when she walked out the front door. LPN #5 stated, "CNA (#7) came and told me that Resident #51 was outside. They put a wanderguard on the resident the next day. No, prior to that she had not made comments about going home or made any attempts to leave. Procedure, unfortunately, I was suppose to right</p>	F 323		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445411	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/16/2015
NAME OF PROVIDER OR SUPPLIER APPLINGWOOD HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1536 APPLING CARE LANE CORDOVA, TN 38018		
(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 7</p> <p>away do event note and call supervisor I did not do that. I wrote in nursing notes that resident was found outside wandering. At that moment I was not aware that event note was to be done. I told incoming nurse in report, in the morning. I found out it was too late when the Administrator and DON was made aware. Made a note in FP [Family Practitioner] book for a wanderguard. I'm a full time nurse always work 10-6. Been here almost 3 yrs [years]. We get inservice each month and they cover abuse, neglect, elopement. CNA #7 wrote a statement."</p> <p>Interview with the Administrator on 7/16/15 at 9:20 AM, in the sunroom, the Administrator was asked about Resident #51's incident when she walked out the front door and do you do elopement risk on all residents. The Administrator stated, "Yes, it is our policy, on admission, quarterly and as needed if there is a significant change. No ma'am, no exit seeking behaviors, she would always say she wanted to go home, never known to sit up in the lobby. Stay very much to her room. From the 3/26 to 4/14/15 no one mentioned that she had left building. The minute we found out, we started my investigation. Staff was informed of the importance of reported incidents immediately." The Administrator was asked if a thorough investigation was completed for Resident #51's falls. The Administrator stated, "We go over in the morning meeting all falls, we all look at the occurrence and make sure we have the most appropriate interventions in place. Staff interviewed if warranted, most time we encourage statements or bring them into the meeting to explain what happened."</p> <p>3. Medical record review revealed Resident #59 was admitted to the facility on 7/21/14 with</p>	F 323			

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445411	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/16/2015
NAME OF PROVIDER OR SUPPLIER APPLINGWOOD HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1536 APPLING CARE LANE CORDOVA, TN 38018		
(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 8</p> <p>diagnoses of Urinary Tract Infection, Muscle Weakness, Open Angle Glaucoma, Hallucinations, Alzheimer's Disease, Anxiety, Hypertension, Hyperlipidemia, Insomnia, Presenile Dementia, Delusional Disorder, and Senile Psychosis.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated 4/8/15 revealed Resident #59 had a Brief Interview for Mental Status (BIMS) score of 6 indicating severe cognitive impairment.</p> <p>Review of the Elopement Risk Assessment dated 4/17/15 revealed Resident #59 was a high risk for elopement.</p> <p>The nurse's event note dated 6/23/15 at 4:30 PM, documented, "...Summoned to end of 100 hall by... CNA to resident on outside of door sitting in wheelchair trying to get wheelchair out of sidewalk ridge... entered door code and went out of 100 hall door and approached resident slowly from behind and assisted resident back inside while CNA held the door open... IMMEDIATE STEPS IMPLEMENTED TO PREVENT RECURRENCE: Ensure exit doors on each hall are armed every shift by staff..."</p> <p>Observations of the 100 hall exit door on 7/14/15 at 11:10 AM, revealed a locked system with an alarm/keypad and a sign that the exit door should be used only in emergency situations.</p> <p>Interview with Registered Nurse (RN) #1 on 7/14/15 at 11:30 AM, in the sunroom, RN #1 was asked about Resident #59 being found outside. RN #1 stated, "We had a resident that had expired in the last room, the funeral home, was told to come to that door (100 hall). [Named CNA</p>	F 323			

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445411	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/16/2015
NAME OF PROVIDER OR SUPPLIER APPLINGWOOD HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1536 APPLING CARE LANE CORDOVA, TN 38018		
(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 9</p> <p>#2] unlocked the door to disarm the alarm so the funeral director could go out of the door but instead of waiting until they went out with the body she went to take care of another resident. So she left the door and did not watch the door while it was disarmed and forgot about it. She went on about her work."</p> <p>4. Medical record review revealed Resident #92 was admitted to the facility on 2/4/15 with diagnoses of Late Effect Cerebrovascular Disease, Hemiplegia, General Muscle Weakness, Dysarthria, Dysphagia, Diabetes Mellitus, Gouty Neuropathy, Obstructive Chronic Bronchitis, Hypertension, Chronic Kidney Disease, Hyperlipidemia, Presenile Depression, Disc Degeneration, Anemia, Esophageal Reflux, Spinal Stenosis, Gastrostomy Status, and Anxiety Disorder.</p> <p>Review of the Interdisciplinary Team Occurrence Investigation Worksheet revealed:</p> <p>a. A fall occurred on 2/8/15, there was no statement from CNA #3 who discovered Resident #92 on the floor. There was no evidence that CNA #3 attended the Post Occurrence Investigation meeting.</p> <p>b. A fall occurred on 2/18/15, there was no statement from CNA #4 who discovered Resident #92 on the floor. There was no evidence that CNA #4 attended the Post Occurrence Investigation meeting. There was no evidence of 72 hour post fall follow up for 2/20/15 and 2/21/15.</p> <p>c. A fall occurred on 4/1/15, there was no evidence of 72 hour post fall follow up for 4/2/15</p>	F 323		

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

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445411	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/16/2015
NAME OF PROVIDER OR SUPPLIER APPLINGWOOD HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1536 APPLING CARE LANE CORDOVA, TN 38018		
(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 10 and 4/3/15.</p> <p>d. A fall occurred on 4/12/15 there was no statement from CNA #5 who discovered Resident #92 on the floor. There was no evidence that CNA #5 attended the Post Occurrence Investigation meeting.</p> <p>Interview with RN #1 on 7/14/15 at 10:54 AM, in the sunroom, RN #1 was asked if the fall investigations for 2/8/15, 2/18/15, 4/1/15, and 4/12/15 were complete. RN #1 stated, "Missing some things here." RN #1 was asked if there should be a witness statement,. RN #1 stated, "Sometimes we have the CNA's or whoever discover the resident attend the Team Meeting [Post Occurrence Investigation]." RN #1 confirmed that CNA #3, 4, and 5 did not attend the meeting that was held after Resident #92 fell on 2/8/15, 2/18/15, and 4/12/15. RN #1 confirmed that there was no 72 hour post fall follow up for the falls on 2/18/15 and 4/1/15.</p> <p>5. Observations in room 304 and 305 on 7/14/15 beginning at 10:05 AM, revealed the sharps containers were full.</p> <p>6. Observations in the 100 hall spa on 7/14/15 at 8:55 AM, revealed an unlocked cabinet with a razor inside.</p> <p>Interview with RN #1 on 7/16/15 at 2:03 PM, in the Assistant Director of Nursing office, RN #1 was asked if it was acceptable for a razor to be left unsecured. RN #1 stated, "No. Razors should always be secured."</p>	F 323			

RECEIVED

AUG 14 2015