

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 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 000	INITIAL COMMENTS	F 000		
F 253 SS=F	<p>Complaint investigations were initiated with the recertification survey on 7/13/15 - 7/16/15. A deficient practice was cited on the following complaints: TN36555 - F309 and TN36556, TN36876 and TN35992 - F323.</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of job descriptions, observation and interview, the facility failed to provide effective housekeeping services to maintain a sanitary, orderly and comfortable environment as evidenced by dried brown substance on walls, floors and commodes; cobwebs; dirty and stained privacy curtains; dirt and grime on the floors; garbage on the floor and odors in 38 of 41 rooms (Rooms 100, 101, 102, 103, 104, 105, 106, 108, 109, 110, 112, 113, 114, 115, 116, 117, 118, 120, 200, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 301, 302, 303, 304, 305, 306, 307, 309 and 311).</p> <p>The facility's failure to provide effective housekeeping services to maintain a sanitary, orderly and comfortable environment resulted in substandard quality of care.</p> <p>The extended survey was conducted on 7/16/15.</p> <p>The findings included:</p>	F 253	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility will provide housekeeping and maintenance services necessary to maintaining a sanitary, orderly, and comfortable interior.</p> <p>Corrective Action:</p> <ol style="list-style-type: none"> On 7/15/15 and 8/14/15 the housekeeping and floor technician job description was reviewed with all environmental staff. From 7/15/15 to 8/15/15 the following was completed on the 100 Hall by the facility staff. <ul style="list-style-type: none"> (A) Room 100 bathroom floor was cleaned, trash was removed from the trash can and cobwebs were removed from the corners of the walls. (B) Room 101 bathroom exhaust fan was cleaned and bathroom floor cleaned. The corner beside the hall door was cleaned. (C) Room 102 the dirt and grime next to the wall was removed. The bathroom floor was swept and mopped. (D) Room 103 the toilet bowl was cleaned. (E) Room 104 the room was mopped and new fall mats were placed down beside the bed. The bathroom exhaust fan was cleaned, the walls were washed and the floor and baseboard were cleaned. (F) Room 105 the floors, baseboards and corners were cleaned. The bathroom floor was mopped and the elevated commode seat was cleaned. (G) Room 106 bathroom floor was mopped, commode seat was cleaned and walls were washed. (H) Room 108 entrance room wall was cleaned. The bathroom wall was washed, the elevated commode seat was cleaned, and the shower floor was mopped. 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Stacy Woodson* TITLE *Administrator* (X6) 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.

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F 253	Continued From page 1 1. The facility's housekeeper job description documented, "...The purpose of this position is to perform the day-to-day activities of the Housekeeping Department in accordance with current federal, state, and local standards, and the facility's policies and procedures... Clean assigned zone, proceeding in an orderly fashion and doing a complete job, including... Doors and door frames... Walls... Patient room furniture... Any item prone to dust collection... ensure proper order... and completion of trash removal... Discard waste and trash into proper containers..." The facility's floor technician (tech) job description documented, "...The purpose of this position is to perform day-to-day activities of buffing, waxing and other tasks in accordance with current federal, state, and local standards, guidelines and regulations to assure that the facility is maintained in a clean, safe and comfortable manner... Clean assigned zone, proceeding in an orderly manner and completing the job... Discard waste and trash into proper containers... Assure that work assignment areas are clean..." 2. Observations on the 100 hall on 7/13/15 beginning at 8:40 AM and 2:35 PM, on 7/14/15 at 8:40 AM, 10:20 AM, and at 3:00 PM, revealed the following: a. Room 100 - bathroom (BR) had dirt and grime on the floor under the sink and behind the commode, trash in the can, cobwebs in the corners of the walls. Interview with the Administrator on 7/15/15 at 8:30 AM, in room 100, the Administrator was asked if she recognized the issues with room	F 253	(I) Room 109 bed A privacy curtain was cleaned. The bathroom walls were washed and toilet was cleaned. (J) Room 110 empty curtain bracket was removed. The bathroom floor was mopped. The floor and baseboards were cleaned in the room. (K) Room 112 the rust around the toilet was removed. The bathroom floor was mopped and the commode seat was cleaned. (L) Room 113 walls were washed and the brown substance around the electrical outlet was cleaned. (M) Room 114 floor was swept and mopped, the exposed curtain bracket was removed, the bathroom shower was cleaned, sink faucet was cleaned, the bathroom floor was mopped and the commode was cleaned. (N) Room 115 bathroom commode seat was cleaned the floor was swept and mopped and the privacy curtains were cleaned. (O) Room 116 bathroom floor and corners were cleaned, the shower bench was cleared of any hanging items, the bathroom walls were cleaned above the emergency pull cord, the shower walls were cleaned, the floor around the commode was cleaned and the stack of cups were removed from the floor behind the commode. (P) Room 117 bathroom ceiling was dusted to get rid of the cobwebs, the wall next to the entrance door was washed and the A-bed privacy curtain was cleaned. (Q) Room 118 bathroom floor was mopped, the shower stall was cleaned and the edges around the door frames were cleaned. (R) Room 120 the bathroom floor was mopped, the door facing was cleaned and the base of the commode was cleaned. 3. From 7/15/15 to 8/15/15 the following was completed on the 200 Hall by the facility staff. (A) Room 200 A-bed privacy curtain was cleaned. (B) Room 202 floor was swept and mopped, corners were cleaned of any debris and bathroom floors and corners were swept and mopped.	

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F 253	<p>Continued From page 2</p> <p>100. The Administrator stated, "I do, it does need cleaning."</p> <p>b. Room 101 - BR exhaust fan was dusty and dirt and grime along the wall on the floor. Build-up of dirt in the corner on the floor beside the hall door.</p> <p>Interview with the Administrator on 7/14/15 at 7:40 AM, in room 101, the Administrator was asked if she recognized the issues with room 101. The Administrator stated, "Yes." The Administrator was asked if it was acceptable for the room to be dirty. The Administrator stated, "No, it's not."</p> <p>c. Room 102 - dirt and grime build-up along the wall on the floor. The BR had a dirt and grime build-up on the floor and in the corners and pieces of paper towels were on the floor.</p> <p>Interview with the Administrator on 7/14/15 at 7:45 AM, in room 102, the Administrator was asked if she recognized the issues with Room 102. The Administrator stated, "Yes." The Administrator was asked if it was acceptable for the room to be dirty. The Administrator stated, "No."</p> <p>d. Room 103 - brown substance on the sides of the toilet bowl.</p> <p>e. Room 104 - urine odor in the room and the fall mat on right side of the bed was torn. BR had cobwebs in the exhaust fan, dried substance on wall above the tissue holder, black scuff marks on the walls, dirt and grime buildup on the floor along the wall and in the corners.</p> <p>f. Room 105 - dirt and grime on the floor along</p>	F 253	<p>(C) Room 203 bathroom walls were washed and floors were swept and mopped.</p> <p>(D) Room 204 the walls were washed and the floors/corners were swept. The bathroom walls were washed and floors/corners cleared of debris and mopped.</p> <p>(E) Room 205 the floor was swept and mopped and the dirt and grime build-up along the wall was wiped away.</p> <p>(F) Room 206 the privacy curtain was washed, the wall next to the television was washed, the corners were cleaned and the bedside table was dusted. The bathroom commode was cleaned, the extended commode seat was cleaned, the walls were washed, and the floor was swept and mopped.</p> <p>(G) Room 207 bathroom commode was cleaned, the floor was mopped, and the walls were washed. The toilet was flushed and the dirt and grime along the wall was wiped away.</p> <p>(H) Room 208 the corners in the room were cleaned of debris and the wall behind the door was wiped down.</p> <p>(I) Room 209 bathroom floor was swept and mopped.</p> <p>(J) Room 210 the wall under the beside table beside the television was cleaned.</p> <p>(G) Room 211 the dirt and grime along the wall was wiped down and removed, the bathroom commode was cleaned, the floor was swept and mopped, and the bathroom walls were cleaned.</p> <p>4. From 7/15/15 to 8/15/15 the following was completed on 300 Hall by the facility staff.</p> <p>(A) Room 301 the bathroom commode was cleaned.</p> <p>(B) Room 302 the head wall in the room was washed and the bathroom floor was swept and mopped.</p> <p>(C) Room 303 the dirt and grime along the wall was wiped away, the bathroom floor was mopped and the cobwebs in the bathroom was removed.</p> <p>(D) Room 304 the cobwebs were removed from the</p>	

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F 253	<p>Continued From page 3</p> <p>the walls and in the corners. The BR had dried brown spots on the floor by the commode, dirt and grime on the floor and the elevated commode seat had dirt and brown stains.</p> <p>g. Room 106 - BR with dirt and grime on the floor, commode seat and the BR wall had a dried brown substance on it.</p> <p>h. Room 108 - the entrance room wall of the room had splattered stains and dirt. The BR wall and the elevated commode seat had a dried brown substance on it and the shower floor was dirty.</p> <p>i. Room 109 - bed A privacy curtain had brown stains on it. The BR had a dried brown substance on the wall beside the commode, feces in the toilet and a dried brown substance splattered behind the toilet and below the sink near the baseboard.</p> <p>Interview with the Administrator on 7/14/15 at 7:50 AM, in room 109, the Administrator was asked if she recognized the issues with room 109. The Administrator stated, "Okay, yes, ma'am, I understand your concerns. I have seen enough."</p> <p>j. Room 110 - no curtains over the windows with exposed empty curtain bracket, noted several brown shoe prints on bathroom floor as well as brown flakes of dirt on the floor. The floors in the room and the BR had dirt and grime build-up.</p> <p>k. Room 112 - rust around the base of the toilet. The floor had dirt and grime build-up around the shower and the commode seat had a brown substance on it.</p>	F 253	<p>front of the B-side closet, the light switch in the bathroom was cleaned, the shower stall was wiped down, the shower curtain was cleaned, the bathroom walls were washed down.</p> <p>(E) Room 305 the cove base was cleaned, the wall at the head of the bed was washed, the cobwebs in the bathroom were removed and the dirt and grime build-up in the corners were cleaned.</p> <p>(F) Room 306 the cobwebs between the closet and the wall were removed, the cobwebs between the bedside table and the wall were removed, the bathroom floor was mopped and the shower curtain was cleaned.</p> <p>(G) Room 307 was deep cleaned and urine smell dissipated, in the bathroom the floor next to the wall was cleaned and the commode base was cleaned. The privacy curtain was cleaned and the bathroom floor was swept and mopped.</p> <p>(H) Room 309 the dirt and grime on the floor along the wall was cleaned, the dirt and grime on the floor along the wall in the bathroom was cleaned, the bathroom floor was swept and mopped, and the commode base was cleaned.</p> <p>(I) Room 311 the washcloth laying on the bathroom floor was removed and the floor was swept and mopped.</p> <p>5. On 8/15/15 the Administrator completed a 100% room check on 100, 200 and 300 halls to ensure that patient rooms and bathrooms were free from dirt and grime along the walls, cobwebs were not present, that the walls were free of any dirt or stains, that the corners were free of debris, exhaust fans were free of dust, the showers were cleaned, commodes and commode bases were clean, privacy curtains were free of stains, and that the floors are swept and mopped.</p> <p>6. On 7/15/15 and 8/14/15 the housekeeping and floor tech staff was in-serviced by the Administrator regarding the importance of maintaining a sanitary, orderly and comfortable interior for our patients. This includes maintaining</p>		

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F 253	Continued From page 4 l. Room 113 - the wall next to the bed had a dried, brown substance around the electrical outlet. m. Room 114 - dirty, used paper towels on the floor; brown shoe prints on the floor; dried brown substance on the floor; exposed curtain brackets with no curtains on the window; a red substance in the shower; the sink faucet had mildew on it, dirt on the floor around the shower, and dried black smears on the side of the commode. n. Room 115 - BR had dried brown substance on the commode seat and on the back of the commode by the handle, food particles on the floor, dirt and grime build-up on the floor along the walls, and the privacy curtains were dirty and stained. Interview with the Administrator on 7/14/15 at 7:45 AM, in room 115, the Administrator was asked if she recognized the issues with room 115. The Administrator stated, "Yes, Ma'am." o. Room 116 - dirt and grime build-up in the corners of the BR floor; a used towel was hanging on the shower bench; a dried brown substance was on the wall above the emergency pull cord; dirt and grime on the shower walls; dirt around the commode base and stacked cups were on the floor behind the commode. Interview with the Administrator on 7/14/15 at 7:42 AM, in room 116, the Administrator was asked if the room looked clean to her. The Administrator stated, "No, Ma'am it's not. Honestly I don't think we have the right housekeepers in place."	F 253	an environment that is free of dirt and grime along the walls, cobwebs, dirt or stains on the walls, corners free of debris, clean exhaust fans, showers, commodes, privacy curtains and a floor that is swept and mopped. 7. The Administrator and department heads will monitor for compliance through random daily rounding of the patient rooms and bathrooms for the next three months. All 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, the environmental staff which includes the housekeeping and floor techs will be re-in-serviced and random daily rounding of patient rooms and bathrooms until compliance is met. Completion date:	8/16/2015	

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F 253	Continued From page 5 p. Room 117 - BR had cobwebs on the ceiling; the wall next to the entrance door had a brown, dried substance on the wall and the A-bed privacy curtain had brown stains on it. q. Room 118 - BR had a dirt and grime build-up on the floor; the shower stall was dirty and the door facing had a dirt build-up around the edges. r. Room 120 - BR had a dirt and grime build-up on the floor, the bottom of the door facing had a dirt build-up on it and there was a rust color substance around the base of the commode. 3. Observations on 200 hall on 7/13/15 beginning at 9:02 AM, and 7/14/15 beginning at 8:15 AM, revealed the following: a. Room 200 - A-bed privacy curtain had brown stains on it. b. Room 202 - dirt and grime build-up on the floor along the wall at the head of the bed; dirt, grime and food particles in the corners of the floor and the BR had a dirt and grime build-up on the floor along the wall and in the corners. c. Room 203 - BR had food particles and a dried brown substance on the wall under the tissue holder; floor had a dirt and grime build-up in the corner under the sink. d. Room 204 - the wall had dried food particles on it and a dead bug on the floor in the corner beside the door. The BR had a dried brown substance running down the walls and dirt and grime build-up along the wall on the floor, a dried reddish brown substance splattered on the wall and dirt and grime on the floor.	F 253			

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F 253	Continued From page 6 e. Room 205 - dirt and grime build-up and trash particles on the floor and dirt and grime build-up along the wall on the floor. f. Room 206 - the privacy curtain between the beds was dirty and stained, dried brown substance on the wall next to the television, dirt and grime in the corners and along the wall and the bedside table next to the window was dusty. The BR had a dried brown substance on the commode, the extended commode seat and on the wall and there was a dirt and grime on the floor. g. Room 207 - BR had a dried brown substance on the commode rim, the floor around the commode, and the wall under the tissue holder. The commode had not been flushed and contained tissue and urine and the floor had a dirt and grime along the wall. h. Room 208 - the corner of the wall beside the bathroom had dried liquid stains on the wall behind the door. i. Room 209 - BR had pieces of paper towel on the floor. j. Room 210 - red splatters on the wall under the bedside table beside the television. g. Room 211 - dirt and grime along the wall on the floor, the BR had feces in the commode, dirt, grime, and paper towels on the floor, and stains and dirt on the wall. 4. Observations on 300 hall on 7/14/15 beginning at 9:50 AM, revealed the following:	F 253			

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F 253	Continued From page 7 a. Room 301 - BR commode tank had dried brown splatters on it. b. Room 302 - the wall at the head of the bed was stained, and the BR had a dried brown stains on the floor behind the commode. c. Room 303 - dirt and grime on the floor along the wall and the BR floor had dirt and grime build-up and cobwebs behind the commode. d. Room 304 - cobwebs in front of the B-side closet, the light switch to the BR had a dried brown substance on it, the BR shower stall had dirt on the floor, the curtain ends were touching the floor and folded back with black ends, the walls were stained with dried brown smear, and the wall behind the bathroom door had a dried brown substance on it. e. Room 305 - the cove base was dirty, dirt spots on the wall at the head of the bed, the BR had cobwebs in the wall corners, and a dirt and grime build-up in the corners of the floor. f. Room 306 - cobwebs between the closet and wall, cobwebs between the bedside table and the wall, the BR had a dirt and grime build-up on the floor, and the shower curtain had dried brown spots on it. g. Room 307 - urine odor in the room, the BR had a dirt and grime on the floor along the wall and the commode base was dirty. The privacy curtains were stained and dirty and the BR had dirt and grime on the floor. Interview with housekeeping staff (HS) #1 on	F 253		

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F 253	<p>Continued From page 8</p> <p>7/14/15 at 10:00 AM, in room 307, HS #1 was asked if she could smell an odor. HS #1 stated, "Urine." HS #1 was asked where the urine odor was coming from. HS #1 stated, "I don't know."</p> <p>h. Room 309 - dirt and grime on the floor along the wall, the BR had a dirt and grime build-up on the floor along the wall, paper towels on the floor, and the commode base was dirty.</p> <p>i. Room 311 - BR had a used washcloth laying on the floor and there was a dirt and grime build-up on the floor.</p> <p>Interview with the Administrator on 7/14/15 at 7:40 PM, in the sunroom, the Administrator was asked about the housekeeping staffing and responsibilities. The Administrator stated, "Three plus a floor tech, if census doesn't allow for 3 then a minimum of 2. Daily they have their own sections, responsible for a set of rooms, dust, sweep, mop, clean the bathroom, if a mattress needs wiping down then they do that." The Administrator was asked who oversees the housekeepers. The Administrator stated, "I try to get out there as often as I can but more him [maintenance supervisor] than me."</p> <p>Interview with HS #2, on 7/15/15 at 9:05 AM, in the dining room, HS #2 was asked what her job duties were. HS #2 stated, "Dust, wipe down, sanitize bedside tables, toilets, empty trash cans, pull beds from walls-thorough sweep then mop, restock resident supplies. Rush so you can get off the floor before breakfast trays out, then go back after breakfast. Clean dining room, go back to floor, off hall during lunch then go back to clean the dining room again then go back to the floor." HS #2 was asked about staffing housekeeping.</p>	F 253			

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NAME OF PROVIDER OR SUPPLIER APPLINGWOOD HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1536 APPLING CARE LANE CORDOVA, TN 38018	
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F 253	Continued From page 9 HS #2 stated, "Usually 2 in housekeeping, a floor tech." HS #2 was asked who was responsible for cleaning the walls. HS #2 stated, "Want us [housekeepers] to clean even walls if need to. Blinds suppose d to be taken down and pressure washed by [named floor tech]."	F 253		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 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. The findings included: 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	F 309	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. Corrective Action: 1. On 6/6/15 Resident #89 was discharged from the facility. 2. Nurse management completed 100% audit on 8/14/15 of as needed pain medications for documented reason for administration. 3. All licensed nurses were in-serviced on 7/17/15, by Regional Nurse Consultant on proper documentation of as needed pain medications. 4. 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. Completion date:	8/16/2015

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F 309	<p>Continued From page 10 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, 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</p>	F 309			

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F 309	Continued From page 11 administration documented on the MAR. 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" 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	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		

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F 323	<p>Continued From page 12</p> <p>by:</p> <p>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 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 in status... 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</p>	F 323	<p>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.</p> <p>(C) Resident #92 discharged from the facility on 5/15/2015.</p> <p>(D) All falls/occurrences audited on 8/13/15 for investigations with appropriate statements attached for review by fall meeting committee with 72 hour follow up.</p> <p>(E) On 8/13/15 all over-filled sharps containers replaced as necessary.</p> <p>(F) On 8/13/15 all resident areas and shower rooms were assessed for hazards, such as razors, and removed accordingly.</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.</p> <p>(C) On 8/14/15 Nurse management conducted audit of fall investigations for necessary statements and 72 hour follow up.</p> <p>(D) On 8/14/15 Nurses management conducted audited of fall meetings with appropriate staff in attendance, as necessary.</p> <p>(E) On 8/13/15 Nurse management conducted rounds to replace all over-filled sharps containers in resident areas and shower rooms.</p> <p>(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</p>		

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F 323	<p>Continued From page 13</p> <p>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, Catarct, Chronic Kidney Disease.</p> <p>The significant change Minimum Data Set (MDS) 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</p>	F 323	<p>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>	8/16/2015	

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F 323	<p>Continued From page 14 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 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</p>	F 323			

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F 323	<p>Continued From page 15 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 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</p>	F 323			

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F 323	<p>Continued From page 16</p> <p>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 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</p>	F 323		

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F 323	<p>Continued From page 17</p> <p>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 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</p>	F 323			

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F 323	<p>Continued From page 18 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 #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</p>	F 323			

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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 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 19</p> <p>#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 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>	F 323			

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F 323	Continued From page 20 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."	F 323			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and interview, the facility failed to ensure drug	F 329	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen will be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Corrective Action: 1. Resident #59 assessed by Nurse Management, on 7/16/12 and found to have no adverse affect from lack of lab obtained. 2. On 7/20/15 a 100% lab audit conducted by Regional Nurse Consultant on all residents receiving Depakote. 3. All licensed nurses were in-serviced by the Regional Nurse Consultant, on 7/17/15 and 8/14/15, regarding proper lab values required. 4. The DON and/or designee will monitor for compliance through 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, all licensed nurses will be re-in-serviced and audits will continue until compliance is met. Completion date:	8/16/2015	

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F 329	<p>Continued From page 21</p> <p>levels were monitored for 1 of 5 (Resident #59) sampled residents reviewed for unnecessary medication use.</p> <p>The findings included:</p> <p>The "Clinical Pathway for Laboratory Monitoring" policy documented, "...Additional labs to be ordered if the patient is on the following medications... Depakote (Valproic acid)... Depakote level... q [every] 3 months..."</p> <p>Medical record review revealed Resident #59 was admitted to the facility on 7/21/14 with diagnoses of Urinary Tract Infection, Hallucinations, Alzheimer's Disease, Muscle Weakness, Anxiety, Hypertension, Hyperlipidemia, Insomnia, Presenile Dementia, Open Angle Glaucoma, Delusional Disorder, and Senile Psychosis.</p> <p>The physician orders dated 5/21/15 documented, "...DEPAKOTE SPRINKLE 125mg [milligram] (2) CAPSULE, SPRINKLE Oral... One Time Daily Starting 12/19/14..."</p> <p>The facility was unable to provide documentation that a Depakote level had been done every 3 months per facility policy.</p> <p>Interview with Registered Nurse (RN) #1 on 7/15/15 at 6:04 PM, in the sunroom, confirmed that a Depakote level had not been done for Resident #59.</p> <p>Telephone interview with the Psychiatric Nurse Practitioner (PNP) on 7/16/15 at 1:25 PM, the PNP was asked if a Depakote level should be drawn every 3 months as per the facility policy. The PNP stated, "Should be."</p>	F 329			

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F 371 SS=D	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, the facility failed to maintain the daily temperature log for the refrigerator in 1 of 1 (nurses' station) nourishment room.</p> <p>The findings included:</p> <p>The facility's "GENERAL INFORMATION... PERISHABLE FOODS ITEMS" policy documented, "...All perishable foods will be stored at proper temperatures... Refrigerated food items at or below 41 F [Fahrenheit]... The temperature of all cold storage units is checked and recorded daily..."</p> <p>Observations in the nourishment room at the nurses' station on 7/16/15 at 1:30 PM, revealed the "Refrigerator Temperature Log" above the refrigerator. There were no temperatures recorded for 7/13/15, 7/14/15, and 7/15/15.</p> <p>Interview with the Registered Nurse (RN) #1 on 7/16/15 at 2:51 PM, in the Assistant Director of Nursing (ADON) office, RN #1 was asked how</p>	F 371	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/ SERVE-SANITARY</p> <p>The facility must-</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions.</p> <p>Corrective Action:</p> <p>1. Nurse Management assessed nursing station nourishment room refrigerator for proper temperature recorded appropriately on 7/16/15 and 8/13/15. 2. Nurse Management conducted audit on 8/13/15 on all refrigerators for proper temperatures recorded. 3. All licensed nurses in-serviced on 7/17/15 and 8/14/15, by Regional Nurse Consultant, for storage, proper recording of temperatures on all refrigerators. 4. Nurse Management will monitor for compliance through random audits of refrigerator temps 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, will monitor for compliance through review of random audits for three months. If compliance is not met, licensed nurses will be re-in-serviced and audits will continue until compliance is met.</p> <p>Completion Date:</p>	8/16/2015	

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F 371	Continued From page 23 often resident nutrition refrigerator temperatures should be checked. The ADON stated, "Daily." RN #1 was asked when was the last time the temperature was checked according to the refrigerator temperature log. RN #1 stated, "July 12th."	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Corrective Action: 1. Resident #59 was assessed by Nurse Manager, on 7/20/15 with documented findings of no adverse affect from glucometer monitoring. (b) Med cart on 200 hall cleaned by Nurse Management on 7/17/15. (c) Nurse Managers reviewed donning and doffing of gloves with hand hygiene with licensed nurses #2 and #4, use of barrier for glucometer, cleaning with proper germicidal wipe, on 7/17/15. 2. All glucometers were cleaned by nurse management and licensed nurses with the proper germicidal wipe, using barriers on 7/17/15. (b) All med carts audited for cleanliness on 8/13/15 by nurse management. (c) All nurses were audited by nurse management for proper donning and doffing of gloves with proper hygiene by 7/21/15. 3. All licensed nurses were in-serviced on cleaning of glucometers with proper germicidal wipes, using barrier, clean med carts for administration of medication, donning and doffing of gloves with proper hand hygiene on 7/21/15, by Regional Nurse Consultant. 4. Nursing Management will monitor for compliance through random audits for the next three months.	

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F 441	Continued From page 24 (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 policy review, observation, and interview, the facility failed to ensure practices to prevent the potential spread of infection were maintained when a barrier was not used with a glucometer, hand hygiene was not performed between glove use, and/or a glucometer was not disinfected between resident use by 2 of 5 (Registered Nurse (RN) #2 and Licensed Practical Nurse (LPN) #4) nurses administering medications, and a dirty medication cart on 1 of 3 (200 hall medication cart) medication carts. The findings included: 1. The facility's "Blood Glucose Testing" policy documented, "...The glucometer must be cleaned and disinfected between each patient use..." The facility's "Hand Hygiene" policy documented, "...Hand hygiene is the simplest, most effective means of infection control... Hand hygiene must be performed at a minimum... Before donning gloves and after removing gloves..." 2. Observations in Resident #59's room on 7/13/15 at 11:34 AM, revealed RN #2 cleansed a glucometer with a sani-wipe, then placed the glucometer on the dresser without a barrier between the glucometer and the dresser, and	F 441	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, all licensed nurses will be re-in-serviced and random audits will continue until compliance is met. Completion Date:	8/16/2015

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F 441	<p>Continued From page 25 proceeded to perform the accucheck.</p> <p>Interview with RN #1 on 7/16/15 at 3:08 PM, in the Assistant Director of Nursing (ADON) office, RN #1 was asked the steps for an accucheck. RN #1 stated, "Lay out a barrier in the room." RN #1 was asked if it was acceptable to place a glucometer on a bare dresser without a barrier after cleaning it. RN #1 stated, "No it is not."</p> <p>3. Observations in Resident #59's room on 7/14/15 at 5:26 PM, revealed LPN #4 cleansed an accucheck with an alcohol prep, walked to the medication cart, and placed the accucheck in the drawer of the medication cart. LPN #4 applied gloves, prepared 2 units of Novolog, and removed her gloves, without performing hand hygiene. LPN #4 prepared 15 units of Humalog 75/25, removed her gloves, without performing hand hygiene, went to Resident #59's room, applied gloves, and then administered each of the insulins.</p> <p>Interview with the Director of Nursing (DON) on 7/15/15 at 10:30 AM, in the DON office, the DON was asked what should be done with an accucheck between resident use. The DON stated, "Should clean it." The DON was asked what should the accucheck be cleansed with. The DON stated, "A germicidal wipe." The DON was asked what should be done in between glove use (removing gloves and applying new gloves). The DON stated, "Should wash their [staff] hands."</p> <p>4. Observations in the 200 hall on 7/15/15 at 9:40 AM, revealed the medication cart with a large amount of splattered brown and reddish substance on the back and lower right side.</p>	F 441			

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F 441	Continued From page 26 Interview with LPN #2 on 7/15/15 at 9:45 AM, in the 200 hall, LPN #2 was asked about the large amount of splattered brown and reddish substance on back and lower right side of medication cart. LPN #2 stated, "I really don't know what that is. I tried to get it off yesterday with a sani-wipe and it would not come off. I need to give this cart a good cleaning." LPN #2 then obtained a sani-wipe and began to wash the area of the brown, reddish splatter and the substance came off on the wipe. LPN #2 stated, "That really worries me."	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 2 (100 hall) spas was clean and sanitary. The findings included: Observations in the 100 hall spa on 7/13/15 at 9:02 AM and on 7/14/15 at 8:55 AM, revealed the shower had dirt and grime on the floor, the inside of the whirlpool was dirty, the corner facing was peeling off and there was a hole in the wall next to the door. The commode had feces sitting in brown water with a dated piece of tape floating on top dated "6/26". The toilet bowl had a distinct ring around the inside of the bowl, the ceiling	F 465	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The facility will provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Corrective Action: 1. On 7/20/15 the 100 hall shower room was power washed by the floor tech to remove the dirt and grime on the floor and in the shower. On 7/20/15 the Maintenance director cleaned the whirlpool, the corner facing was repaired and painted, and the hole next to the door was repaired and painted. On 7/15/15 the commode in the shower room was flushed and scrubbed, the ceiling light bulbs were replaced and bathroom floor was swept and mopped by the Maintenance director. On 7/20/15 the broken and missing tiles along the floor were replaced and the shower and bathroom were also dusted by the maintenance director. 2. On 8/13/15 the Administrator completed an audit regarding the cleanliness of the 100 and 200 shower rooms. 3. On 7/15/15 and 8/14/15 the housekeeping and floor techs were in-serviced by the Administrator regarding the cleaning of the 100 and 200 hall shower rooms. Cleaning includes shower, whirlpool, walls, bathrooms and floors. On 8/14/15 the	

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F 465	Continued From page 27 lights did not turn on when the switch was flipped on and the bathroom floor had a dried, brown stain on the floor, a hole in the wall next to the entrance door, the shower stall had dirt on the floor, the floor beside the shower was dirty, tiles along the wall were broken in several places with 1 tile missing completely. The wall corner beside the shower had broken sheet rock, with metal visible with a sharp edge. A dead bug was on the floor, toilet tissue on the floor, and thick dust along the door frame of the hall door. Interview with the Administrator on 7/15/15 at 8:35 AM, in the 100 hall spa the Administrator was asked if the spas were used for resident showers. The Administrator stated, "Yes." The Administrator was shown the bathroom (BR), the Administrator stopped at the BR door and stated, "I can see it from here, not acceptable in any form or fashion. I've had issues since I've been here day one with both spas."	F 465	Maintenance Director was in-serviced by the Administrator regarding repairing of corners, cracked or missing tile, replacing of burnt out lighting, and repairing of holes in the wall. 4. The Administrator and/or designee will monitor randomly through daily rounding for three months to ensure the cleanliness of the 100 and 200 shower rooms. 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, housekeeping and floor techs will be re-in-serviced and audits will continue until compliance is met. Completion Date:	8/16/2015	
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, the facility failed to be administered in a manner that ensured 38 of 41 rooms (Rooms 100, 101, 102, 103, 104, 105, 106, 108, 109, 110, 112, 113, 114, 115, 116, 117, 118, 120, 200, 202,	F 490	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility will be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Plan of Correction: 1. From 7/15/15 to 8/15/15 the facility Administration and staff cleaned and repaired Rooms 100, 101, 102, 103, 104, 105, 106, 108, 109, 110, 112, 113, 114, 115, 116, 117, 118, 120, 200, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 301, 302, 303, 304, 305, 306, 307, 309 and 311. 2. On 8/15/15 the Administrator completed an audit regarding the cleanliness of all 41 patient rooms/bathrooms. This was done to ensure that		

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F 490	Continued From page 28 203, 204, 205, 206, 207, 208, 209, 210, 211, 301, 302, 303, 304, 305, 306, 307, 309 and 311) resident's rooms were clean. The findings included: Administration failed to ensure 38 of 41 resident rooms were maintained and clean as evidenced by dried splattered substance on the walls and commodes, dirt and grime build-up on the floors, dried splattered liquid stains on the walls, cobwebs in the corners of the walls, brown splatters and stains on the privacy curtains, food particles on the floors, dead bugs on the floors, unflushed commodes with urine and/or feces and tissue, dust in the bathroom exhaust fans, black scuff marks on walls, trash and pieces of paper in the floors, stacked cups on the floor behind commodes, sink faucets with black substance that looked like mold or mildew, stains around the bases of commodes, dried brown substance on the inside bowl of the commodes, dusty bedside tables, dried food particles on the walls, urine odors, used towels and washcloths on the floors and showers, shower curtains with a black substance at the bottom, and dirty commode tanks. Refer to F253.	F 490	patient's room and bathroom walls were clean, commodes are clean, that the floor along the wall was free of dirt and grime, that the corners of the walls were free of cobwebs, privacy curtains are clean, floors are swept, commodes are flushed, bathroom exhaust fans are free from dust, scuff marks on the walls are cleaned, bathroom and room floors are free of clutter, faucet sinks are cleaned, outside of the commodes are free of any stains, rooms are free of dust, rooms are odor free, used towels and washcloths are disposed of correctly, shower curtains are clean and that commode tanks are clean. 3. On 8/14/15 the facility administration was in-serviced by the Regional Director of Operations regarding facility rounding in patient room and bathrooms to ensure cleanliness for those areas. 4. The Administrator and/or designee will complete random daily rounding for 3 months to ensure that patient rooms and bathrooms are clean. 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, the administrator will be Completion Date:	8/16/2015
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review	F 502	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Corrective Action: 1. Resident #59 was assessed by Nurse Management on 7/20/15, with documented findings of no adverse affect from missing lab with notification of physician. 2. 100% lab audit conducted by Regional Nurse Consultant on 7/17/15, of labs ordered and	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445411	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 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		
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F 502	<p>Continued From page 29</p> <p>and interview, the facility failed to obtain laboratory tests as ordered by the physician for 1 of 31 (Resident #59) sampled residents included in the stage 2 review.</p> <p>The findings included:</p> <p>The "Clinical Pathway for Laboratory Monitoring" policy documented, "...Upon Admission, the following labs and referrals are to be ordered and started... All patients... CBC [complete blood count]... q [every] 6 months..."</p> <p>Medical record review revealed Resident #59 was admitted to the facility on 7/21/14 with diagnoses of Urinary Tract Infection, Hallucinations, Alzheimer's Disease, Muscle Weakness, Anxiety, Hypertension, Hyperlipidemia, Insomnia, Presenile Dementia, Open Angle Glaucoma, Delusional Disorder, and Senile Psychosis.</p> <p>The physician orders dated 5/21/15 documented, "...CBC [complete blood count] with diff [differential]... Every Six Months Starting 07/22/14..."</p> <p>The facility was unable to provide documentation that a CBC with diff had been done for Resident #59 since 9/3/14.</p> <p>Interview with Registered Nurse (RN) #1 on 7/15/15 at 6:04 PM, in the sunroom, RN #1 confirmed that a CBC with diff had not been done every 6 months as ordered by the physician for Resident #59 since 9/3/14.</p>	F 502	<p>obtained with documented findings.</p> <p>3. All licensed nurses in-serviced on 7/17/15, of following physician orders for obtaining labs with follow up of notification of lab values by Regional Nurse Consultant.</p> <p>4. Nurse Management will monitor for compliance through 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, all licensed nurses will be re-in-serviced and audits will continue until compliance is met.</p> <p>Completion Date:</p>	8/16/2015	

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AUG 14 2015