

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

PRINTED: 03/05/2013
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 02/28/2013
--	--	--	--

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 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <ul style="list-style-type: none"> Based on policy review, medical record review and interview, it was determined the facility failed to develop a comprehensive care plan to address the needs of palliative care for 1 of 16 (Resident #52) resident care plans reviewed in the stage 2 sample of the 32 residents included in the stage 2 review. <p>The findings included:</p> <p>Review of the facility's "Care Plans" policy documented, "...The care plan must describe the</p>	F 279	<p>F 279 483.2(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS SS=D</p> <p>Requirement:</p> <p>A facility will use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility will develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p>	
---------------	--	-------	---	--

RECEIVED
APR 11 2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>George Munchow</i>	TITLE <i>Administrator</i>	(X6) DATE 3/14/13
--	-------------------------------	----------------------

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.

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 02/28/2013
--	--	--	--

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 279	<p>Continued From page 1</p> <p>services that are to be furnished to attain and maintain the patient's highest practical physical, mental and psychosocial wellbeing... The care plan... Must be reviewed every 90 days and as needed. [As needed] may mean... b) Each readmission after hospitalization c) When there is a change in patient status..."</p> <p>Review of the facility's "Palliative Care Legal Aspects of Care" policy documented, "The patient's goals, preferences and choices are respected within the limits of applicable state and federal law, and form the basis for the plan of care... Palliative care promotes advance care planning in order to understand and communicate the patient's or surrogate's preferences for care across the health care continuum..."</p> <p>Medical record review for Resident #52 documented an admission date of 1/16/13 with diagnoses of Sepsis, Urinary Tract Infection, Muscle Weakness, Hypertension, Senile Delusion, Osteoarthritis, Depressive Psychotic Disorder, Vitamin D deficiency, Hypothyroidism, Hyperlipidemia and Anxiety. Review of a physician's order dated 1/24/13 documented, "...Palliative Care..." Review of the physician's progress notes dated 1/24/13 documented, "...family discussion re [regarding]: current status, loss of appetite... Palliative care, comfort measures..." Review of the care plan dated 1/28/13 for Resident #52 did not address palliative care or comfort measures.</p> <p>During an interview in the sun room on 2/27/13 at 4:10 PM, Nurse #3 was asked if the facility has a care plan for comfort measures for Resident #52. Nurse #3 stated, "No we don't..."</p>	F 279	<p>Plan of Correction:</p> <ol style="list-style-type: none"> 1. Resident #52 comprehensive care plan was updated to include Palliative care on 3/1/2013. 2. An audit was completed by the MDS Coordinators on 3/1/2013 regarding palliative care patients to ensure for accuracy of their care plans. 3. The Director of Nursing in-serviced the MDS Coordinators on 3/1/2013 regarding the accuracy of care plans for palliative care patients. 4. The Director of Nursing and/or Assistant Director of Nursing will monitor monthly for compliance regarding all new palliative care patients. Findings will be reported to the QA committee quarterly for the next two quarters. <p style="text-align: right;">Completion Date: 3/15/2013</p>	3/15/13
-------	---	-------	--	---------

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

PRINTED: 03/05/2013
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 02/28/2013
--	--	--	--

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 279 Continued From page 2

F 279

During an interview at the nurses' station on 2/27/13 at 5:00 PM, the Director of Nursing (DON) was asked if a resident is on comfort measures and palliative care, would she expect to see a care plan for comfort measures for the staff to know how to provide care to the resident. The DON stated, "Yes, I would..." The DON was then asked what do your comfort measures consist of. The DON stated, "I would expect them to control pain, keep the area and my body clean, give emotional and spiritual support to the resident and the family, and provide care for whatever it takes to complete the comfort..."

F 282
SS=D 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

F 282

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

F 282
483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN
SS=D

Requirement:

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation and interview, it was determined the facility failed to follow the comprehensive care plan interventions related to falls for 1 of 16 (Resident #125) residents with care plans reviewed in the stage 2 sample of the 32 residents included in the stage 2 review.

The services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care.

The findings included:

Medical record review for Resident #125 documented an admission date of 1/18/13 with diagnoses of Acute/Chronic Congestive Heart

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 02/28/2013
--	--	--	--

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 282	<p>Continued From page 3</p> <p>Failure, Hypertension, Acute Kidney Failure, Deep Vein Thrombosis, Peripheral Vascular Disease, and Acute Encephalopathy. Review of the care plan dated 1/30/13 documented, "...actual fall... Interventions... encourage resident to remain in the center of bed (mats placed on floor besides bed for additional safety)..." The facility was not following the care plan interventions for fall mats related to falls.</p> <p>Observations in room Resident #125's room on 2/26/13 at 11:00 AM, revealed there were no fall mats in the room as care planned.</p> <p>During an interview in the Minimum Data Set office on 2/27/13 at 5:45 PM, Nurse #3 was asked to provide the fall interventions for Resident #125. Nurse #3 was reading the interventions and stated, "We don't use the mats anymore I don't think... we need to take that [the mats] off there [the care plan]... I'm not sure but I think we do need to take that off..."</p> <p>During an interview in Resident #125's room on 2/27/13 at 5:50 PM, the Director of Nursing (DON) was asked where the fall mats would be. The DON stated, "No mats in here... I've been here since July [2012] we had them then if they stopped using them I didn't know it..." The DON was then asked why would you stop using the mats. The DON stated, "I don't know, I need to find out..."</p> <p>During an interview in the hall beside the nurses' station on 2/27/13 at 6:05 PM, the DON stated, "We do still use them [mats] I spoke with [Named Administrator] so we will get some and place them in her room..."</p>	F 282	<p>Plan of Correction:</p> <ol style="list-style-type: none"> 1. Resident #125 had mats placed at bedside on 3/1/2013. 2. A chart audit was completed by the MDS Coordinators for patients with falls to ensure that interventions were appropriate and in place. 3. The Director of Nursing in-serviced licensed nurses, CNAs, MDS Coordinators, and Therapy staff on 3/4/2013 regarding the progressive steps taken when ensuring the accuracy of fall interventions. 4. The Director of Nursing and/or Assistant Director of Nursing will monitor monthly for compliance by ensuring interventions for falls were appropriate and in place. Findings will be reported to the QA committee quarterly for the next two quarters. <p>Completion Date: 3/15/2013</p>	3/15/13
-------	--	-------	---	---------

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

PRINTED: 03/05/2013
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 02/28/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER APPLINGWOOD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1636 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 332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation, and interview, it was determined 1 of 5 (Nurse #1) medication nurses failed to administer medications with a medication error rate of less than 5 percent (%). A total of 3 errors were observed out of 52 opportunities for error, resulting in a medication error rate of 5.76%.</p> <p>The findings included:</p> <p>Review of the facility's "SPACING AND PROPER SEQUENCE OF INHALED MEDICATIONS" policy documented, "...Wait one minute between "puffs" for multiple inhalations of the same drug... Wait 1- [to] 2 minutes before administering next drug..."</p> <p>Medical record review for Resident #20 documented an admission date of 12/3/12 with diagnoses of Atherosclerotic Heart Disease, Diabetes, Cognitive Impairment, Coronary Artery Disease, Dyslipidemia, Hypertension and Chronic Obstructive Pulmonary Disease. Review of the physician's orders dated 1/7/13 documented, "...Salmeterol / Fluticasone 250/50 mcg [micrograms] diskus [1] puff MDI [multiple dose inhalation] INH [inhalation] BID [twice a day]... Tiotropium 18 mcg MDI INH QD [every day]..."</p> <p>Review of the physician's orders dated 2/8/13</p>	F 332	<p>F 332 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>Requirement:</p> <p>The facility will ensure that it is free of medication error rates of five percent or greater.</p> <p>Plan of Correction:</p> <ol style="list-style-type: none"> 1. For Resident #20 the Nurse Practitioner was notified of the medication errors regarding the inhalers medication time sequence and the missed Ativan. The Nurse Practitioner gave no new orders regarding the inhalers and a new order was received to give the Ativan on 2/28/2013. 2. The Director of Nursing and/or the Assistant Director of Nursing completed an audit to ensure that medication administration is being conducted per medication protocol and in compliance of physician orders. 3. The Director of Nursing in-serviced on 3/4/2013 licensed nurses regarding medication protocol and administration. 4. The Director of Nursing and/or the Assistant Director of Nursing will audit for compliance with medication pass observations monthly. Findings will be reported to the QA committee quarterly for the next two quarters. <p>Completion Date: 3/15/2013</p>	3/15/13
---------------	--	-------	--	---------

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

PRINTED: 03/05/2013
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 02/28/2013
--	--	--	--

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 332 Continued From page 5 documented, "...[Change] Ativan to 0.5 mg [milligrams] [1] po [by mouth] BID- Q [every] AM, Q HS [hour of Sleep]..."

Observations in Resident #20's room on 2/28/13 at 9:50 AM, revealed Nurse #1 administered medications to Resident #20 but did not administer Ativan 0.5 mg. The failure to give the Ativan 0.5 mg resulted in medication error #1.

During an interview on the 100 hall on 2/28/13 at 10:40 AM, Nurse #1 was questioned concerning the Ativan 0.5 mg not given to Resident #20. Nurse #1 stated, "...it was ordered, I must have overlooked it..."

Observations in Resident #20's room on 2/28/13 at 9:55 AM, Nurse #1 administered 1 puff of Tiotropium inhaler to Resident #20, then administered 1 puff of Salmeterol / Fluticasone inhaler to Resident #20 without waiting 1-2 minutes between puffs. The failure to wait 1-2 minutes between puffs for each inhaler resulted in medication errors #2 and 33.

During an interview in the Director of Nursing's (DON) office on 2/28/13 at 5:00 PM, the DON confirmed Nurse #1 should wait 1-2 minutes between puffs of an inhaler.

F 371 483.35(i) FOOD PROCURE, SS=D STORE/PREPARE/SERVE - SANITARY

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

F 332

F 371

F 371
483.35(i) FOOD PROCURE,
STORE/PREPARE/SERVE - SANITARY
SS=D

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

PRINTED: 03/05/2013
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 02/28/2013
--	--	--	--

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 371	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure food was prepared or stored under sanitary conditions as evidenced by 2 of 5 (Dietary workers #1 and #2) dietary workers had hair exposed while preparing the trays on the tray line.</p> <p>The findings included:</p> <p>Review of the facility's "Dietary Service Training Manual" documented "...PERSONAL HYGIENE ...3. Hair covering must be worn at all times with all hair under covering..."</p> <p>Observations in the kitchen on 2/28/13 at 11:50 AM, while preparing trays from the steam table dietary worker #1 and #2's hair was exposed under the cap. Dietary worker #1 had hair hanging to the shoulders not covered by the cap and dietary worker #2 had her hair on her forehead that was not covered by the cap.</p> <p>During an interview in the hall outside of the dining room with on 2/28/13 at 6:30 PM, the Dietary Manager (DM) was asked about dietary workers hair being covered while preparing trays. The DM stated, "I really did not see that... I guess I wasn't paying attention. I was so focused on doing the [food] temps [temperatures]."</p>	F 371	<p>Requirements:</p> <p>The facility will --</p> <ol style="list-style-type: none"> (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>Plan of Correction:</p> <ol style="list-style-type: none"> 1. The Dietary employees #1 and #2 were immediately advlsed on 3/1/2013 to completely cover their hair. 2. The Dietary Manager then inspected on 3/1/2013 the remaining dietary staff to ensure compliance of wearing a hair covering. 3. The Dietary Manager on 3/4/2013 In-serviced the dietary staff regarding personal hygiene and hair covering must be worn at all times with all hair under covering. 4. The Dietary Manager will continually inspect to insure compliance with hair coverings. Findings will be reported to the QA committee for one quarter. <p>Completion Date: 3/15/2013</p>	3/15/13
F 372	483.35(i)(3) DISPOSE GARBAGE & REFUSE	F 372	<p>F 372 483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY SS=D</p>	

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 02/28/2013
--	--	--	--

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 372 SS=D	<p>Continued From page 7 PROPERLY</p> <p>The facility must dispose of garbage and refuse properly.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to properly store garbage in a covered dumpster on 2 of 3 (2/27/13 and 2/28/13) days of the survey.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Observations of the facility's dumpster in the parking lot on 2/27/13 at 12:00 PM, revealed filled trash bags overflowing out of the the top of the dumpster with cardboard boxes and ceiling tiles laying against the fence that surrounded the dumpster. 2. Observations of the facility's dumpster with the Dietary Manager (DM) present on 2/28/13 at 3:15 PM, revealed the dumpster contained filled white trash bags plled up overflowing out of the the top of the dumpster. Broken trash bags containing food were hanging out of the side with food noted on the ground. <p>Observations of the facility's dumpster on 2/28/13 at 3:30 PM, revealed a cat jumping out of the dumpster and another cat was slitting on top of the dumpster's top.</p> <p>During an interview on 2/28/13 at 4:00 PM, the (DM) stated, "It's [garbage] overflowing... the garbage is not picked up till [until] tomorrow... It</p>	F 372	<p>Requirement: The facility will dispose of garbage and refuse properly.</p> <p>Plan of Correction:</p> <ol style="list-style-type: none"> 1. On Thursday 2/28/2013 the dumpster was emptied at 6am. 2. The Administrator and maintenance director will monitor weekly for the next month relative to the frequency for determination if more trash pick-ups are necessary. 3. The Administrator in-serviced facility staff on 3/15/2013 regarding keeping the dumpster doors and lid completely closed and trash is completely contained within the dumpster. 4. The maintenance and/or designee will monitor to ensure that dumpster doors and lid and completely closed and trash is completely contained. Findings will be reported to the QA committee for one quarter. <p>Completion Date: 3/28/2013</p>	3/28/13
---------------	---	-------	---	---------

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

PRINTED: 03/03/2013
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 02/28/2013
--	--	--	--

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 372 Continued From page 8
[garbage] is picked up twice a week."

During an interview in the sunroom on 2/28/13 at 5:00 PM, the Administrator stated, "The garbage is picked up twice a week."

F 406 483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES
SS=D

If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.

This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review, observation, and interview, it was determined the facility failed to obtain a physician order for speech therapy services for 1 of 3 (Resident #118) sampled residents of the 27 residents included in the stage 2 review receiving rehabilitation services.

The findings included:

Review of the facility's "Director of Nursing Training Manual Physician's Orders" policy documented, "...REQUIREMENTS Must have SPECIFIC physician orders for the following areas ...h. Physical Therapy, Occupational Therapy, Speech Therapy..."

F 372

F 406

F 406
483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES
SS=D

Requirements:

When specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitation, are required in resident's comprehensive plan of care, the facility will provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.

Plan of Correction:

1. Resident #118 received an order on 3/5/2013 for specialized speech therapy.
2. On 3/4/2013 the Therapy Director audited physical therapy, speech-language pathology, and occupational therapy orders to ensure that the chart had the proper orders.

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

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 02/28/2013
--	--	--	--

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 406

Continued From page 9

Medical record review for Resident #118 documented an admission dated of 12/3/12 with an diagnoses of Urinary Tract Infection, Congestive Heart Failure, Chronic Renal Insufficiency, Cerebral Vascular Accident, Anemia, Hypertension, Atrial Fibrillation, Hypothyroidism, Neuropathy, Peripheral Vascular Disease, Gastro Esophageal Reflux Disease, Diabetes Mellitus, Hyperlipidemia, Hemiplegia, and Dementia. Review of the 14 day Minimum Data Set (MDS) assessment dated 12/17/12 documented speech therapy start date of 12/4/12. Review of the January 2013 and February 2013 physician orders did not include a recertification order for speech therapy services.

Observations in the physical therapy department on 2/27/13 at 7:25 AM, revealed the speech therapist working with Resident #118.

During an interview in the physical therapy department on 2/28/13 at 7:30 AM, the occupational therapist assistant was asked to find the orders for continued speech therapy for Resident #118. The speech therapist stated, "I can't find it... I can't find the renewal order for speech therapy."

During an interview in physical therapy department on 2/28/13 at 9:20 AM, the physical therapy supervisor was asked if there was an order for continued speech therapy for Resident #118. The physical therapy supervisor stated, "No... we need an order [for continued speech therapy]..."

F 406

3. The Therapy Director in-serviced on 3/4/2013 the physical therapists, speech therapists, and occupational therapists regarding obtaining the proper physician orders to provide therapy.
4. The Therapy Director will audit therapy orders weekly for one month, then monthly for one quarter. Findings will be reported to the QA committee quarterly for the next two quarters.

Completion Date: 3/15/2013

3/15/13

F 431
SS=D

483.60(b), (d), (e) DRUG RECORDS,
LABEL/STORE DRUGS & BIOLOGICALS

F 431

F 431
483.60(b), (d), (e) DRUG RECORDS,
LABEL/STORE DRUGS & BIOLOGICALS
SS=D

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

PRINTED: 03/05/2013
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 02/28/2013
--	--	--	--

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 431	<p>Continued From page 10</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observation, and</p>	F 431	<p>Requirements:</p> <p>The facility will employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled dugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biological used in the facility will be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility will store all drugs and biological in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility will provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>	

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 02/28/2013
--	---	--	---

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 431	<p>Continued From page 11</p> <p>interview, it was determined 1 of 5 (Nurse #1) medication nurses failed to ensure medications were stored in locked compartments when unattended and out of their sight.</p> <p>The findings included:</p> <p>Review of the facility's "SECURITY OF MED [medication] CART AND MED PREP [preparation] ROOM" policy documented, "...The med cart must remain in the nurse's line of vision... The cart must be locked and all medications secured when unattended..."</p> <p>Observations in front of room 103 on 2/28/13 at 10:06 AM, revealed Nurse #1 was preparing medications for a resident at the medication cart. Nurse #1 placed Polyethylene Glycol and an Exelon patch on top of the medication cart. Nurse #1 walked away from the medication cart to obtain a cap for the Polyethylene Glycol at the nurses' station, leaving these two medications on top of the medication cart unattended and out of her sight.</p> <p>During an interview in the Director of Nursing's (DON) office on 2/28/13 at 5:00 PM, the DON and the Assistant Director of Nursing (ADON) were asked what is the expectation when medications are left on the medication cart and the nurse leaves the medication cart. The ADON stated, "[Nurses] Should not leave the meds unattended... will have to do another inservice..."</p>	F 431	<p>Plan of Correction:</p> <ol style="list-style-type: none"> 1. Nurse #1 secured her medication cart on 2/28/13 and was in-serviced by the Director of Nursing on 3/4/2013 regarding the security of medications. 2. All medication carts were checked on 3/1/2013 to ensure that medication were secured and safely locked. 3. The Director of Nursing in-serviced licensed nurses on 3/1/2013 and 3/4/2013 of compliance with medication storage, locking of carts and that medication is in view of the nurse when dispensing. 4. The Director of Nursing and/or the Assistant Director of Nursing will routinely round for three month to ensure for compliance with medication storage, locking of carts and that medication are in view of the nurse when dispensing. Findings will be reported to the QA committee quarterly for the next two quarters. <p>Completion Date: 3/15/2013</p>	3/15/13
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a</p>	F 441	<p>F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS SS=D</p>	

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

PRINTED: 03/05/2013
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 02/28/2013
--	--	--	--

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 441	<p>Continued From page 12 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observation, and</p>	F 441	<p>Requirements:</p> <p>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.</p> <p>Plan of Correction:</p> <ol style="list-style-type: none"> 1. For Residents #61 and #72 the MD was notified on 3/1/2013 of the improper application of the Exelon topical patches and no further orders were given. 2. Nurse #1 and #2 were in-serviced by the Director of Nursing on 3/1/2013 regarding proper placement of patches and Hand Hygiene. 3. Director of Nursing on 3/4/2013 in-serviced licensed nurses regarding proper application of patches and Hand Hygiene. 4. The Director of Nursing and/or the Assistant Director of Nursing will perform random checks during daily rounds for one month, then weekly for the next two months. Findings will be reported to the QA committee for one quarter. <p>Completion Date: 3/15/2013</p>	3/15/13
-------	---	-------	--	---------

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

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 02/28/2013
--	--	--	--

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 441	<p>Continued From page 13</p> <p>interview, it was determined 2 of 5 (Nurse #1 and 2) medication nurses failed to ensure infection control practices were followed to prevent the spread of infection during medication administration.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Observations in Resident #61's room on 2/28/13 at 10:15 AM, Nurse #1 removed an Exelon topical patch from Resident #61's left upper back, and applied an Exelon topical patch to Resident #61's right upper back. Nurse #1 did not cleanse the skin prior to applying the patch. <p>During an interview in the Director of Nursing's (DON) office on 2/28/13 at 5:00 PM, the DON was asked what is the expectation when administering a topical patch. The DON stated, "Should cleanse the skin prior to applying the patch..."</p> <ol style="list-style-type: none"> 2. Review of the facility's "Hand Hygiene" policy documented, "...Hand Hygiene is the simplest, most effective means of infection control. The term hand hygiene refers to actions intended to decrease the number of contamination microorganisms on the skin... Hand hygiene must be performed at a minimum... Before and after each patient contact... Before donning gloves and after removing gloves..." <p>Observations in Resident #72's room on 2/28/13 at 8:30 AM, Nurse #2 removed an Exelon topical patch from Resident #72's left upper back, and applied an Exelon topical patch to Resident #72's right upper back. Nurse #2 did not cleanse the skin prior to applying the patch.</p>	F 441		

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

PRINTED: 03/09/2013
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 02/28/2013
--	--	--	--

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 441	<p>Continued From page 14</p> <p>Observations in Resident #14's room on 2/28/13 at 9:35 AM, revealed Nurse #2 administered medications to Resident #14, assisted this resident to bed touching the resident and the resident's wheelchair, applied gloves, and administered nose spray to Resident #14. Nurse #2 did not wash her hands after touching the resident and the wheelchair or prior to applying gloves and administering the nose spray.</p> <p>During an interview in the DON office on 2/28/13 at 5:00 PM, the DON was asked what is the expectation when administering medications a topical patch and nasal spray, and touching such things as the resident or equipment. The DON stated, "Should cleanse the skin prior to applying the patch... should wash hands, apply gloves, then administer the med [medication]..."</p>	F 441		
-------	---	-------	--	--

RECEIVED
APR 11 2013