

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

JUN 13 2014

PRINTED: 06/01/2014
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 05/15/2014
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 156 SS=E	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal</p>	F 156	<p>F 156</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>SS=E</p> <p>Requirements:</p> <p>This facility will inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility will provide the resident with notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification will be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, will be acknowledge in writing.</p> <p>Corrective Action:</p> <p>1. Resident #28 and Resident #128 have both discharged from the facility and no further action can be taken to correct the Notice of Medicare Non-Coverage form.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Stacy Wilson</i>	TITLE <i>Administrator</i>	(X6) DATE <i>6-12-14</i>
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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 156	<p>Continued From page 1 funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p>	F 156	<p>2. On 6/12/14 the Social Services Director reviewed current residents receiving skilled services to ensure that proper/timely notice are being given to the resident/families before Medicare services are ending and issuing the "Notice of Medicare Non-Coverage" form.</p> <p>3. The Administrator in serviced the Social Services Director on 6/13/14 regarding the proper/timely notice being given when using the "Notice of Medicare Non-Coverage" form.</p> <p>4. The Administrator and/or designee will randomly monitor for 3 months to ensure that door in the building are closing correctly. Findings will report their findings to the QA Committee consisting of the Medical Director, Administrator, Director of Nursing, Assistant Directors of Nursing, MDS Coordinators, Staffing Coordinator, Dietary Supervisor, Social Worker, Maintenance Supervisor, and Activity Coordinator. If compliance is not met the QA team will re-in-service the Social Services Director and will continue monitoring until substantial compliance is achieved.</p> <p>Completion Date: 6/18/14</p>	6/18/14

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F 156	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to provide 2 of 3 (Residents #28 and 128) sampled residents with the proper advanced beneficiary notices as required by law.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of advanced beneficiary notices for Resident #28 revealed the effective date that the coverage would end was 1/10/14. Resident #28 was notified on 1/10/14, as documented on the dated signature of the power of attorney on the "Notice of Medicare Non-Coverage" form. 2. Review of advanced beneficiary notices for Resident #128 revealed the resident's end of coverage date was 12/24/13. Resident #128 signed the "Notice of Medicare Non-Coverage" form on 12/23/13. 3. During an interview in the administrator's office on 5/13/14 at 1:35 PM, the administrator was asked about the advanced beneficiary notices. The administrator stated, "I'll be honest with you, the social worker we had before was not doing her part in some things. That's why she isn't here anymore." <p>During an interview in the administrator's office on 5/14/14 at 4:50 PM, the administrator was asked how much notice is given before the end of coverage for services. The administrator stated, "If we are exhausting their days, they are going to</p>	F 156		

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F 156	Continued From page 3 know roughly, [we] always do at least a 3-day notice."	F 156	F 278		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to include the	F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED SS=D Requirements: The assessment will accurately reflect the resident's status. A registered nurse will conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse will sign and certify that the assessment is completed. Each individual who completes a portion of the assessment will sign and certify the accuracy of that portion of the assessment. Corrective Action: 1. For Resident #69 on 6/11/14 the MDS Coordinator modified the resident's MDS ARD 1/15/14 and 4/9/14 to reflect the change in diagnosis to include that of Congestive Heart Failure. 2. On 6/11/14 thru 6/18/14 the MDS Coordinators completed an audit to ensure that the correct diagnoses are being included in the MDS.		

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F 278	Continued From page 4 diagnosis of Congestive Heart Failure (CHF) on a Minimum Data Set (MDS) for 1 of 18 (Resident #69) sampled residents of the 32 residents included in the stage 2 review. The findings included: Medical record review for Resident #69 documented an admission date of 5/6/13 with diagnoses of Dementia, Hypertension, Anemia, Anxiety, Presenile Depression, Reflux Disease, Chronic Pain, Hyperlipidemia, Insomnia, Peripheral Neuropathy, Edema, Hypopotassemia and Constipation. Review of a significant change MDS with an assessment reference date (ARD) of 6/28/13, documented that Resident #69 had a condition or chronic disease that may result in a life expectancy of less than 6 months. Review of a physician's order dated 10/18/13 documented, "...Change [named hospice service] terminal dx [diagnosis] to E/S [end stage] CHF..." Review of a quarterly MDS with an ARD of 1/15/14 and a quarterly MDS with an ARD of 4/9/14 did not include the diagnosis of Congestive Heart Failure (CHF). During an interview in the MDS office on 5/14/14 at 9:47 AM, Nurse #4 was asked if the diagnosis of CHF should be listed on the MDS. Nurse #4 stated, "Yes."	F 278	3. The Administrator and the Director of Nursing in serviced the MDS Coordinators on 6/13/14 regarding the importance of the resident's current diagnoses being reflected in the MDS. 4. The Director of Nursing, Assistant Director of Nursing and/or designee will monitor for compliance through random chart audits for the next three months and report their findings to the QA Committee consisting of the Medical Director, Administrator, Director of Nursing, Assistant Directors of Nursing, MDS Coordinators, Staffing Coordinator, Dietary Supervisor, Social Worker, Maintenance Supervisor, and Activity Coordinator. If compliance is not met the QA team will re-in-service the MDS Coordinators and will continue monitoring until substantial compliance is achieved. Completion Date: 6/18/14	6/18/14	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280			

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F 280	<p>Continued From page 5</p> <p>incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, it was determined the facility failed to revise the care plan related to diagnoses, foley catheters, Activities of Daily Living (ADL) and gastrostomy status for 1 of 18 (Resident #26) sampled residents of 32 residents included in the stage 2 review.</p> <p>The findings included:</p> <p>Medical record review for Resident #26 documented an admission date of 9/21/12 with diagnoses of Dysphagia, Gastrostomy Status, Urinary Tract Infection, Diabetes Mellitus, Atrial Fibrillation, Hypertension, Muscle Weakness, Peripheral Neuropathy, Esophageal Reflux,</p>	F 280	<p>F 280</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>SS=D</p> <p>Requirements:</p> <p>The resident will have the right, unless, adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan will be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the president's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p>	
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F 280	<p>Continued From page 6</p> <p>Anxiety Disorder, Constipation, Thyrotoxicity, Tear Film Insufficiency, Presenile Depression, Chronic Obstructive Pulmonary Disease, Allergic Rhinitis, Vitamin D Deficiency, Urinary Retention and Diarrhea.</p> <p>Review of the physician's order dated 2/28/14 documented, "...Resume feeding as previously ordered. Jevity 1.5 can [1] pp [per Percutaneous Endoscopy Gastrostomy] bolus QID [four times per day]... 200mL [milliliters] flush [with] each feeding..."</p> <p>Review of the physician orders dated 4/30/14 documented, "...Notes... D/C [discontinue] F/C [foley catheter] after 24hrs [hours] of bladder training... Order Date: 3/10/2014..."</p> <p>Review of a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/7/14 documented in Section H, Bladder and Bowel, that Resident #26 did not have an indwelling or an external catheter. The MDS also documented that Resident #26 was always incontinent of bladder and bowel.</p> <p>Review of Resident #26's care plan with an effective date of 8/28/13, documented, "... [Resident #26] to eat all meals in the dining room as tolerated. Monitor food intake at each meal; offer appropriate substitutes for uneaten food... Encourage family/visitors to eat with [Resident #26]... Encourage fluids... Involve [Resident #26] in appropriate social groups at meals... Conjunctivitis both eyes STATUS: Active (Current)... At risk for infection R/T [related to] indwelling catheter... [Resident #26] requires extensive assistance with personal hygiene... Set-up items for personal hygiene. Allow</p>	F 280	<p>Corrective Action:</p> <ol style="list-style-type: none"> 1. For resident #26 on 5/14/14 the MDS Coordinator updated the care plan to reflect the resident's current status related to nothing-by-mouth status, the diagnoses of conjunctivitis and an upper respiratory infection, and the Foley catheter and ADLs. 2. On 6/11/14 thru 6/18/14 the MDS Coordinators completed an audit of the resident care plans to ensure that 3. The Administrator and Director of Nursing in serviced the MDS Coordinators on 6/13/14 regarding the correct representation of the resident's current status when completing a resident care plan. 4. The Director of Nursing, Assistant Director of Nursing and/or designee will monitor for compliance through random chart audits of the resident care plan to ensure that the resident care plan represents the current status of the resident for the next three months and report their findings to the QA Committee consisting of the Medical Director, Administrator, Director of Nursing, Assistant Directors of Nursing, MDS Coordinators, Staffing 		

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F 280	Continued From page 7 [Resident #26] to complete as much of the task as possible... [Resident #26] will demonstrate the ability to ambulate/transfer without fall related injuries... Remind [Resident #26] to call for assistance before moving from bed-to-chair and from chair-to-bed... Provide reminders to use ambulation and transfer assist devices... URI [upper respiratory infection] STATUS: Active..." The care plan was not revised to reflect the current status of the resident related to nothing-by-mouth status, the diagnoses of conjunctivitis and an upper respiratory infection, the foley catheter and ADLs. Observations in Resident #26's room on 5/12/14 at 5:10 PM and on 5/14/14 at 2:20 PM, revealed Resident #26 did not have a foley catheter. During an interview in the MDS office on 5/14/14 at 5:15 PM, MDS Nurse #7 verified the care plan was inaccurate and was not revised to reflect the resident's current status related to nothing-by-mouth status, the diagnoses of conjunctivitis and an upper respiratory infection, the foley catheter and ADLs.	F 280	Coordinator, Dietary Supervisor, Social Worker, Maintenance Supervisor, and Activity Coordinator. If compliance is not met the QA team will re-in-service the MDS Coordinators and will continue monitoring until substantial compliance is achieved. Completion Date: 6/18/14	6/18/14	
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314	F 314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES SS=E Based on the comprehensive assessment of a resident, the facility will ensure that a resident who enters		

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F 314	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on policy review, medial record review and interview, it was determined the facility failed to provide treatment as ordered by the physician for pressure ulcers for 2 of 3 (Residents #26 and 42) sampled residents of the 6 residents with pressure ulcers. The findings included: 1. Review of the facility's "Physician's Orders" policy documented "...Physician orders are the basis for care and treatment and provide the plan of care for the patient... Must have SPECIFIC physician orders for the following areas... Special treatments (pressure ulcer or other wound care..." 2. Medical record review for Resident #26 documented an admission date of 9/21/12 with diagnoses of Dysphagia, Gastrostomy Status, Urinary Tract Infection, Diabetes Mellitus, Atrial Fibrillation, Hypertension, Muscle Weakness, Peripheral Neuropathy, Esophageal Reflux, Anxiety Disorder, Constipation, Thyrotoxicity, Tear Film Insufficiency, Presenile Depression, Chronic Obstructive Pulmonary Disease, Allergic Rhinitis, Vitamin D Deficiency, Urinary Retention and Diarrhea. Review of the physician's order dated 3/4/14 documented, "...Xenaderm-apply to buttocks et [and] periarea [every] shift et PRN [as needed] until resolved... Granulex-apply to [left] et [right] heel [every] shift..." Review of Resident #26's treatment records	F 314	the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Corrective Action: 1. a.) For resident #26 on 5/14/14 the Xenaderm treatment order was clarified by the NP and no new orders were given at this time since the area has been resolved. b.) For resident #42 on 6/11/14 the NP did a complete head to toe assessment since treatments were not followed per physician order and no new orders given. 2. On 6/11/14 the Director of Nursing and/or designee completed an audit of resident's with wounds to ensure that treatments are being done per the physician order and when wound is resolved to discontinue the physician order.	

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F 314	<p>Continued From page 9</p> <p>revealed the following:</p> <p>a. March 2014 - the Xenaderm or the Granulex treatments were not done on the 3/5/14 night shift, 3/17/14 night shift, 3/28/14 evening shift and 3/30/14 evening shift.</p> <p>b. April 2014 - the Xenaderm or the Granulex treatments were not done on the 4/15/14 night shift, 4/20/14 evening and night shifts, 4/21/14 night shift, 4/22/14 night shift, 4/23/14 night shift and 4/27/14 day shift.</p> <p>c. May 2014 - the Xenaderm or Granulex treatment was not done on the 5/4/14 night shift.</p> <p>3. Medical record review for Resident #42 documented an admission date of 7/30/10 with diagnoses of Rheumatoid Arthritis, Dysphagia, Osteoporosis, Encephalopathy, Diabetes, Hypertension, Dementia, Depressive Psychosis and Vitamin D Deficiency. Review of a Braden scale for Resident #42 documented the resident scored 15, indicating the resident was at risk for developing a pressure sore.</p> <p>Review of physician orders dated 12/15/13 documented "...[change] treatment order from Zinc to Xenaderm Q [every] shift-Apply to buttocks/sacrum until resolved..."</p> <p>Review of Resident #42's treatment records for Xenaderm revealed the following:</p> <p>a. January 2014 - the facility was unable to provide a treatment record.</p> <p>b. February 2014 - the resident did not receive Xenaderm treatment to buttocks on every shift on 13 of 28 (1, 2, 7, 8, 9, 14, 15, 17, 18, 21, 22, 23 and 28) days.</p> <p>c. March 2014 - the resident did not receive Xenaderm treatment to buttocks on every shift on 15 of 31 (1, 2, 4, 6, 7, 8, 9, 15, 16, 22, 23, 24, 28,</p>	F 314	<p>3. The Director of Nursing in serviced Licensed and Registered Nurses on 6/13/14 and 6/14/14 regarding documentation of treatments and discontinuing physician orders when an area has resolved.</p> <p>4. The Director of Nursing, Assistant Director of Nursing and/or designee will monitor weekly for 4 weeks and randomly for 2 months to ensure that treatment documentation is being done accordingly and that physician orders are being discontinued after an area in resolved. The Director of Nursing will report their findings to the QA Committee consisting of the Medical Director, Administrator, Director of Nursing, Assistant Directors of Nursing, MDS Coordinators, Staffing Coordinator, Dietary Supervisor, Social Worker, Maintenance Supervisor, and Activity Coordinator. If compliance is not met the QA team will re-in-service the Licensed and Registered Nurses and will continue monitoring until substantial compliance is achieved.</p> <p>Completion Date: 6/18/14</p>	6/18/14

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F 314	<p>Continued From page 10 29 and 31) days.</p> <p>Review of physician orders dated 2/14/14 documented, "...Clean [right] inner buttock [with] NS [normal saline], apply Santyl, and cover [with] foam border Dsg [dressing] [every] day [and] PRN [as needed]..."</p> <p>Review of the treatment administration record for Resident #42 for February 2014 documented the resident did not receive treatment with Santyl to right inner buttock on 2/18/14 as ordered.</p> <p>Review of a physician's order dated 4/6/14 documented "...unstageable to Rt [right] buttock has resolved..."</p> <p>Review of Resident #42's April 2014 treatment record documented the resident continued to receive Xenaderm treatment to buttocks without a physician's order from 4/7/14 through 4/30/14, after the wound was documented to be resolved on 4/6/14.</p> <p>Review of a physician's order dated 4/13/14 documented, "...D/C [discontinue] Xenaderm unstageable to rt [right] buttock-cleanse area with ns, apply Santyl, cover with foam border... change Q day [and] prn..."</p> <p>Review of Resident #42's April 2014 treatment record revealed there was no documentation the resident received the Santyl treatment to the right buttock on 4/13/14 as ordered.</p> <p>4. During an interview in the sun room on 5/14/14 at 11:05 AM, the assistant director of nursing verified the wound treatments were done incorrectly and not as ordered by the physician.</p>	F 314			

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F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</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, review of an Advair</p>	F 431	<p>F 431</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>SS=D</p> <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 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. 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</p>		

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F 431	<p>Continued From page 12</p> <p>Diskus insert, medical record review, observation and interview, it was determined the facility failed to provide proper medication storage as evidenced by medications being left on bedside table unattended and out of the nurses view, medication stored uncapped and opened and undated inhalers stored in 2 of 5 (100 and 200 hall medication carts) medication storage areas.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Review of the facility's "...MEDICATION STORAGE..." policy documented, "...Medications must be properly stored in medication rooms or medication carts and must be securely locked when not in use..." Observations in Resident #125's room on 5/13/14 at 9:30 AM, 10:00 AM and 10:30 AM, revealed a bottle of unopened Latanoprost (Xalatan) ophthalmic solution left unattended on the bedside table out of the nurses' view. <p>During an interview in the 300 hall on 5/13/14 at 10:30 AM, Nurse #3 was asked if the eye drops on the bedside table belong to Resident #125. Nurse #3 stated, "They are." Nurse #3 was asked if they should be on her nightstand. Nurse #3 stated, "No they should not."</p> <ol style="list-style-type: none"> Observations in Resident #126's room on 5/14/14 at 9:13 AM, Nurse #3 left medications unattended and out of sight 5 times during the medication administration when she went to wash her hands. <p>During an interview in the Assistant Director of Nursing (ADON) office on 5/14/14 at 10:15 AM, the ADON was asked what she expected the</p>	F 431	<p>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>Corrective Actions:</p> <ol style="list-style-type: none"> a.) For resident #125 the unopened bottle of Latanoprost ophthalmic solution were removed by the charge nurse from the room on 5/13/14. b.) Nurse #3 was in serviced by Director of Nursing on 6/11/14 regarding not leaving medication out of view while washing hands. c.) The opened, uncapped container of Vasolex stored on the back of 100 Hall medication cart was discarded by the Assistant Director of Nursing on 5/12/14. d.) The undated Advair Diskus inhaler stored on 200 Hall medication cart was removed by the Assistant Director of Nursing on 5/12/14. a.) On 6/13/14, 6/16/14 and 6/17/14 the Director of Nursing, the Assistant Director of Nursing and/or designee completed a room check to ensure that no medication were left in resident rooms. b.) On 6/13/14, 6/16/14 and 		

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F 431	Continued From page 13 nurses to do with medications during hand washing during medication administration. The ADON stated, "I expect them to never leave them [medications] unattended at bedside." 4. Observations on the 100 hall on 5/12/14 beginning at 2:45 PM, revealed an opened, uncapped container of Vasolex stored in the bottom of the 100 hall medication cart for rooms 107 through 120. 5. Review of an Advair Diskus drug insert documented, "...HOW SUPPLIED / STORAGE AND HANDLING... Discard ADVAIR DISKUS 1 month after opening the foil pouch or when the counter reads "0" ...whichever comes first..." Observations on the 200 hall on 5/12/14 beginning at 2:45 PM revealed 2 opened and undated Advair Diskus inhalers stored on the 200 hall medication cart for rooms 201 through 211.	F 431	6/17/14 the Director of Nursing, the Assistant Director of Nursing and/or designee completed a med pass audit. c.) On 6/13/14 the Director of Nursing and/or designee completed a medication cart audit to ensure that every medication/oointment was properly capped and stored. d.) On 6/13/14 the Director of Nursing and/or designee completed a medication cart audit to ensure that there were no undated or out of date medications found on the carts. 3. The Director of Nursing in serviced the Licensed and Registered Nurses on 6/13/14 regarding that medication should not be left unattended by resident bedside; that when dispensing medication they should never turn your back from unsecured medications; medication should be properly stored with a properly working cap; and opened medications needs to be dated/destroyed per manufacture guidelines.		
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	F 441	4. The Director of Nursing, Assistant Director of Nursing and/or designee will randomly monitor weekly for 3 months to ensure that medications are not left unattended in resident's room, that		

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F 431	Continued From page 13 nurses to do with medications during hand washing during medication administration. The ADON stated, "I expect them to never leave them [medications] unattended at bedside." 4. Observations on the 100 hall on 5/12/14 beginning at 2:45 PM, revealed an opened, uncapped container of Vasolex stored in the bottom of the 100 hall medication cart for rooms 107 through 120. 5. Review of an Advair Diskus drug insert documented, "...HOW SUPPLIED / STORAGE AND HANDLING... Discard ADVAIR DISKUS 1 month after opening the foil pouch or when the counter reads "0" ...whichever comes first..." Observations on the 200 hall on 5/12/14 beginning at 2:45 PM revealed 2 opened and undated Advair Diskus inhalers stored on the 200 hall medication cart for rooms 201 through 211.	F 431	medication is stored correctly with a cap and that medication is dated when opened per manufactures guidelines. The Director of Nursing will report their findings to the QA Committee consisting of the Medical Director, Administrator, Director of Nursing, Assistant Directors of Nursing, MDS Coordinators, Staffing Coordinator, Dietary Supervisor, Social Worker, Maintenance Supervisor, and Activity Coordinator. If compliance is not met the QA team will re-in-service the Licensed and Registered Nurses and will continue monitoring until substantial compliance is achieved. Completion Date: 6/18/14	6/18/14
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	F 441	F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS SS=E Requirements: 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.	

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F 441	<p>Continued From page 14 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 observation and interview, it was determined the facility failed to ensure staff prevent the potential spread of infection and cross contamination when 2 of 4 (Nurses #3 and 6) nurses failed to clean stethoscope prior to checking feeding tube placement or stored ointment without a top in 1 of 5 (100 hall medication cart) medication storage areas and oxygen tubing was left laying on the floor.</p> <p>The findings included:</p> <p>1. Observations in Resident #126's room on 5/14/14 at 9:14 AM, Nurse #3 cleaned the</p>	F 441	<p>(a) Infection Control Program the facility will 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 will isolate the resident. (2) The facility will prohibit employees with communicable disease or infected skin lesions from direct contact with resident or their food, if direct contact will transmit he disease. (3) The facility will 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>Corrective Action:</p> <p>1. a.) Nurse #3's stethoscope was cleaned properly on 6/11/14 and the Nurse was in serviced by the Director of</p>	

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F 441	Continued From page 15 stethoscope but then hung it around neck, and checked a the tube placement via auscultation without cleaning the stethoscope. During an interview in the Director of Nursing's (DON) office on 5/14/14 at 5:00 PM, the DON was asked what she expected her nursing staff to do with a stethoscope when checking for feeding tube placement. The DON stated, "I expect them to clean the stethoscope with a disinfectant wipe before using." 2. Observations in the 100 hall on on 5/12/14 at 2:45 PM, Nurse #6 placed a tube of Vasolex in the bottom of the medication cart without a top on it. During an interview in the DON's office on 5/14/14 at 5:00 PM, the DON was asked if it was appropriate to place an opened tube of medication in the medication cart without a top on it. The DON stated, "No, they [nurses] know better." 3. Observations in Resident #26's room on 5/13/14 at 8:00 AM, revealed Resident #26's oxygen tubing was laying on the floor. During an interview in the DON's office on 5/14/14 at 5:00 PM, the DON was asked if it was appropriate for a resident's oxygen tubing to be laying on the floor. The DON stated, "No."	F 441	Nursing on 6/11/14 regarding proper cleaning techniques for disinfecting a stethoscope before/after use. b.) The opened, uncapped container of Vasolex stored on the back of 100 Hall medication cart was discarded by the Assistant Director of Nursing on 5/12/14. c.) The oxygen tubing found lying on the floor in resident #26's room was removed by the Assistant Director of nursing on 5/14/14. 2. a.) On 6/13/14, 6/16/14 and 6/17/14 the Director of Nursing, Assistant Director of Nursing, and/or designee randomly audited licensed and registered nurses to ensure that proper cleaning techniques were being used when cleaning equipment such as stethoscopes. b.) On 6/13/14 the Director of Nursing and/or designee completed a medication cart audit to ensure that every medication/ointment was properly capped and stored. c.) On 6/13/14 and 6/16/14 the Director of Nursing and Assistant Director of Nursing audited residents with oxygen use to ensure that tubing was lying on the floor. 3. The Director of Nursing in serviced the Licensed and Registered Nurses on		
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.	F 502			

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F 441	<p>Continued From page 15</p> <p>stethoscope but then hung it around neck, and checked a the tube placement via auscultation without cleaning the stethoscope.</p> <p>During an interview in the Director of Nursing's (DON) office on 5/14/14 at 5:00 PM, the DON was asked what she expected her nursing staff to do with a stethoscope when checking for feeding tube placement. The DON stated, "I expect them to clean the stethoscope with a disinfectant wipe before using."</p> <p>2. Observations in the 100 hall on on 5/12/14 at 2:45 PM, Nurse #6 placed a tube of Vasolex in the bottom of the medication cart without a top on it.</p> <p>During an interview in the DON's office on 5/14/14 at 5:00 PM, the DON was asked if it was appropriate to place an opened tube of medication in the medication cart without a top on it. The DON stated, "No, they [nurses] know better."</p> <p>3. Observations in Resident #26's room on 5/13/14 at 8:00 AM, revealed Resident #26's oxygen tubing was laying on the floor.</p> <p>During an interview in the DON's office on 5/14/14 at 5:00 PM, the DON was asked if it was appropriate for a resident's oxygen tubing to be laying on the floor. The DON stated, "No."</p>	F 441	<p>6/13/14 and 6/14/14 regarding proper cleaning techniques for disinfecting a stethoscope before/after use, medication should be properly stored with a properly working cap. And on6/13/14 and 6/14/14 the Director of Nursing in serviced both Licensed/Registered Nurses and CNAs regarding how oxygen tubing should not be lying on the floor and if it is the tubing need to be discarded and replaced.</p> <p>4. The Director of Nursing, Assistant Director of Nursing and/or designee will randomly monitor weekly for 3 months to ensure that equipment is being properly cleaned before/after use, that medication is stored correctly with a cap, and that oxygen tubing not be lying on the floor. The Director of Nursing will report their findings to the QA Committee consisting of the Medical Director, Administrator, Director of Nursing, Assistant Directors of Nursing, MDS Coordinators, Staffing Coordinator, Dietary Supervisor, Social Worker, Maintenance Supervisor, and Activity Coordinator. If compliance is not met the QA team will re-in-service</p>	
F 502 SS=D	<p>483.75(j)(1) ADMINISTRATION</p> <p>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.</p>	F 502		

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F 441	Continued From page 15 stethoscope but then hung it around neck, and checked a the tube placement via auscultation without cleaning the stethoscope. During an interview in the Director of Nursing's (DON) office on 5/14/14 at 5:00 PM, the DON was asked what she expected her nursing staff to do with a stethoscope when checking for feeding tube placement. The DON stated, "I expect them to clean the stethoscope with a disinfectant wipe before using." 2. Observations in the 100 hall on on 5/12/14 at 2:45 PM, Nurse #6 placed a tube of Vasolex in the bottom of the medication cart without a top on it. During an interview in the DON's office on 5/14/14 at 5:00 PM, the DON was asked if it was appropriate to place an opened tube of medication in the medication cart without a top on it. The DON stated, "No, they [nurses] know better." 3. Observations in Resident #26's room on 5/13/14 at 8:00 AM, revealed Resident #26's oxygen tubing was laying on the floor. During an interview in the DON's office on 5/14/14 at 5:00 PM, the DON was asked if it was appropriate for a resident's oxygen tubing to be laying on the floor. The DON stated, "No."	F 441	the Licensed and Registered Nurses and will continue monitoring until substantial compliance is achieved. Completion Date: 6/18/14	6/18/14	
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.	F 502	F 502 483.75(j)(1) ADMINISTRATION SS=D Requirements: The facility will provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.		

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 05/15/2014
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 502	<p>Continued From page 16</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to perform laboratory testing as ordered by the physician for 1 of 18 (Resident #67) sampled residents of the 32 residents included in the stage 2 review.</p> <p>The findings included:</p> <p>Medical record review for Resident #67 documented an admission date of 6/22/12 with diagnoses of Dementia with Behavior Disturbances, Anxiety, Senile Delirium, Anemia, Debility, Hypothyroidism, Chronic Obstructive Pulmonary Disease, Hypertension, Insomnia, Depressive Disorder, Osteoarthritis and Alzheimer's Disease.</p> <p>Review of a physician's order dated 1/8/14 documented, "...Depakote level [every] 3 months..." Review of the physician's orders dated 4/16/14 documented, "...LAB ORDERS... DEPAKOTE LEVEL EVERY 3 MONTHS..."</p> <p>During an interview in the Director of Nursing's (DON) office on 5/14/14 at 5:35 PM, the DON was asked about the Depakote levels for Resident #67. The DON stated, "Don't see any lab." The facility was unable to provide results of a Depakote level every three months as ordered.</p>	F 502	<p>Corrective Action:</p> <ol style="list-style-type: none"> 1. For Resident #67 the NP was notified on 5/14/14 of the missed lab and orders were received to obtain the Depakote level. Results were received on 5/14/14 that levels were in range and NP was notified with no new orders given. 2. On 6/10/14 thru 6/13/14 the Director of Nursing and/or designee reviewed lab orders to ensure that labs were being drawn per the physician orders. 3. The Director of Nursing in serviced the Licensed and Registered Nurses on 6/13/14 and 6/14/14 regarding physician orders pertaining to labs and notification to the Lab Company. 4. The Director of Nursing, Assistant Director of Nursing and/or designee will weekly for 3 months to ensure that labs are being done per physician orders. The Director of Nursing will report their findings to the QA Committee consisting of the Medical Director, Administrator, Director of Nursing, Assistant Directors of Nursing, MDS Coordinators, Staffing Coordinator, 		

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F 502	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to perform laboratory testing as ordered by the physician for 1 of 18 (Resident #67) sampled residents of the 32 residents included in the stage 2 review. The findings included: Medical record review for Resident #67 documented an admission date of 6/22/12 with diagnoses of Dementia with Behavior Disturbances, Anxiety, Senile Delirium, Anemia, Debility, Hypothyroidism, Chronic Obstructive Pulmonary Disease, Hypertension, Insomnia, Depressive Disorder, Osteoartrosis and Alzheimer's Disease. Review of a physician's order dated 1/8/14 documented, "...Depakote level [every] 3 months..." Review of the physician's orders dated 4/16/14 documented, "...LAB ORDERS... DEPAKOTE LEVEL EVERY 3 MONTHS..." During an interview in the Director of Nursing's (DON) office on 5/14/14 at 5:35 PM, the DON was asked about the Depakote levels for Resident #67. The DON stated, "Don't see any lab." The facility was unable to provide results of a Depakote level every three months as ordered.	F 502	Dietary Supervisor, Social Worker, Maintenance Supervisor, and Activity Coordinator. If compliance is not met the QA team will re-in-service the Licensed and Registered Nurses and will continue monitoring until substantial compliance is achieved. Completion Date: 6/18/14	6/18/14	