

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

PRINTED: 12/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

45th 01/18/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445162	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/04/2013	
NAME OF PROVIDER OR SUPPLIER  ASBURY PLACE AT JOHNSON CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYTRLE AVENUE JOHNSON CITY, TN 37604		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p><b>INITIAL COMMENTS</b></p> <p>An annual recertification survey and complaint investigation #32191 and #32400, were completed on December 2-4, 2013, at Asbury Place At Johnson City. No deficiencies were cited related to complaint investigation #32400. Deficiencies were cited related to complaint investigation #32191 under 42 CFR PART 482.13, Requirements for Long Term Care Facilities.</p>	F 000	<p>The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This Plan of Correction is filed as evidence of the facility to comply with the requirement of participation and continue to provide high quality resident care.</p>	
F 323 SS=D	<p><b>483.25(f) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b></p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure one resident (#8) of four residents reviewed received adequate supervision and assistive devices to prevent accidents.</p> <p>The findings included:  Medical record review of a Care Plan dated November 11, 2013, revealed "... (Resident #8) is at risk for injuries/falls...Interventions...Status: Active...Bed Alarm..."</p> <p>Medical record review of the Medication Record</p>	F 323	<p><b>F 323 - Free of Accident/Hazards/Supervision/ Device</b></p> <ol style="list-style-type: none"> <li>1. Resident # 8's alarm was plugged back in place on 12/4/13, by LPN # 1.</li> <li>2. All residents with any type of alarms were checked for placement on 12/5/13 by Director of Nursing. All alarms were in place as ordered.</li> <li>3. All licensed nursing staff will be re-educated by the Director of Nursing or RN Supervisor regarding alarm policy and proper alarm placement by 12/23/13.</li> </ol>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Debra Hubbard* TITLE *Executive Director* (X6) DATE

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.

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

PRINTED: 12/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445162	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/04/2013
NAME OF PROVIDER OR SUPPLIER  ASBURY PLACE AT JOHNSON CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYTRLE AVENUE JOHNSON CITY, TN 37604	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 1 for December 1, 2013 through December 31, 2013, revealed "Bed Alarm when in Bed."  Observation of resident #8 with Licensed Practical Nurse (LPN) #1 on December 4, 2013, at 9:10 a.m., revealed the resident lying in bed, eating breakfast. Observation revealed the bed alarm control box secured behind the head board at the head of the bed without the lead wire connected to the box. Continued observation revealed the lead wire connection was laying between the mattress and the slide rail and not connected to the alarm. Further observation revealed LPN #1 connected the lead wire to the control box. Observation revealed LPN #1 was not able to test the alarm due to the alarm being turned off.  Interview with LPN #1 and the Director of Nursing in the Activity Room on December 4, 2013, at 9:20 a.m., confirmed the bed alarm was turned off with the lead wire disconnected from the control box. Continued interview confirmed the facility had failed to ensure the alarm was working appropriately to alert staff to unassisted transfers.	F 323	4. The Director of Nursing or RN Supervisor or LPN Charge Nurse will randomly audit 10 residents with alarms 2 times a week for 4 weeks, then 1 time a week for 4 weeks, and then 1 time a month for 1 month. The results of the alarm audits will be reviewed at the Quality Assurance Committee meeting monthly for three (3) months, beginning with January 2014 QA meeting.	12/22/13
F 371 SS=F	C/O #32191 483.35(i) FOOD PROCURE, 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 371	F 371 - Food Procure, Store/Prepare/Serve- Sanitary  1. On 12/2/13 all pots, pans, oven, steam wells and deep fryer were thoroughly cleaned. On 12/3/13 the iced tea maker and beverage machine were thoroughly cleaned by kitchen staff and Dining Services Director.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445162	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  12/04/2013
NAME OF PROVIDER OR SUPPLIER  ASBURY PLACE AT JOHNSON CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYRTLE AVENUE JOHNSON CITY, TN 37604		
(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	Continued From page 2  This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to maintain a clean and sanitary kitchen.  The findings included:  Observation on December 2, 2013, at 7:35 p.m., during the initial tour of the kitchen revealed: 1. Three of three muffin pans with black crusty debris on the inside and outside and one of three muffin pans had rust colored debris on the inside. 2. Five of six size 400 pans with black crusty debris on the inside and outside and three of the five pans had water droplets on the inside and outside. 3. Twenty of twenty-two size 200 pans were dirty with brown and black debris on the inside. 4. Two of two large deep pans (used to cook meat) with crusty brown and white debris on the inside. 5. Two of two shallow pans (used to cook meat) with crusty brown and white debris on the inside. 6. One of one large dessert pan with black and white debris on the inside. 7. Twenty of twenty-one sheet pans with white crusty debris on the inside.  Continued observation in the kitchen at the food preparation area revealed: 1. Two of two stack convection ovens with black crusty debris and food particles on the inside at the bottom. 2. Five of six wells on the steam table had food debris and white particles floating in the water.	F 371	2. On 12/3/13, the Dietary Manager and Director of Clinical Services developed a performance improvement project to ensure all dietary equipment will be cleaned thoroughly in compliance with the newly designed cleaning schedule.  3. Re-education will be conducted by the Dietary Manager or Production Manager with all staff on new cleaning schedule and frequencies on 12/19/13.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445162	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/04/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  ASBURY PLACE AT JOHNSON CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYTRLE AVENUE JOHNSON CITY, TN 37604
--	---

(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 3</p> <p>One of the five wells also had hair floating in the water.</p> <p>3. One of one free standing deep fryer containing black oil with food particles floating in the oil. Unable to visualize the bottom of the deep fryer due to the blackness of the oil. Also food debris on the outside of the fryer.</p> <p>Observation of the front serving area on December 3, 2013, at 7:15 a.m., revealed:</p> <p>1. The ice tea maker had dark brown sticky areas in numerous areas on the outside of the dispenser. The dispenser was empty...</p> <p>2. The Juice machine had orange dried sticky substance in numerous areas on the outside of the machine.</p> <p>Review of facility policies for cleaning and sanitizing revealed:</p> <p>1. "...Beverage Fountain...Properly Clean and Sanitize Post-Mix Beverage Machines Procedure Frequency: daily..."</p> <p>2. "...Deep Fryer...Cleaning &amp; Sanitizing...Procedure Frequency: Daily: Exterior Weekly...When Needed"</p> <p>3. "...Ice Tea Dispenser...Cleaning &amp; Sanitizing...after each use..."</p> <p>4. "...Oven: Bake/Stack...Degreasing &amp; Cleaning...Frequency: weekly."</p> <p>5. "...Steam Table Cleaning &amp; Sanitizing...Frequency: After each use..."</p> <p>Interview with Dietary Cook #1 on December 2, 2013, in the kitchen during the initial tour and at the time of the first observation confirmed the facility had failed to maintain a clean and sanitary kitchen.</p> <p>Interview with the Dietary Manager on December</p>	F 371	<p>4. Audits will be conducted by the Dietary Manager or Production Manager or Cooks regarding kitchen equipment daily for 2 weeks then 3 times a week for 2 weeks then weekly for 4 weeks and then monthly coupled with impromptu inspections. The results of the audits will be reviewed at the Quality Assurance meeting</p> <p>monthly for three (3) months, beginning with January 2014 QA meeting</p>	12/19/13
-------	---	-------	---	----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445182</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/04/2013</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>ASBURY PLACE AT JOHNSON CITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>105 WEST MYTRLE AVENUE JOHNSON CITY, TN 37804</b>
---	---

(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	Continued From page 4 3, 2013, at 7:20 a.m., in the front serving area confirmed the ice tea maker had not been used since the day before (December 2, 2013). The Dietary Manager also confirmed the substances on the juice machine had not just occurred and the kitchen equipment was not clean and sanitary.	F 371		
F 431 SS=D	<p><b>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</b></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</p>	F 431	<p><b>F 431 – Drug Records, Label/Store Drugs and Biologicals</b></p> <ol style="list-style-type: none"> <li>All expired aspirin, Ondanestron, and Warfarin were removed from the facility's drug circulation by the DON on 12/3/13.</li> <li>All med carts and med rooms were re-inspected for expired drugs by the pharmacy consultant on 12/4/13.</li> </ol>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445162	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  12/04/2013
NAME OF PROVIDER OR SUPPLIER  ASBURY PLACE AT JOHNSON CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYRTLE AVENUE JOHNSON CITY, TN 37604		
(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 5</p> <p>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 observation, review of facility policy, and interview, the facility failed to ensure all medications were in date for one of three medication carts and in one of two medication rooms.</p> <p>The findings revealed:</p> <p>Observation with Licensed Practical Nurse (LPN) #1 on December 3, 2013, at 7:51 a.m., revealed the 100 hall medication cart contained an open bottle of Aspirin 325 mg (milligram) with an expiration date of December 2012.</p> <p>Observation with the Director of Nursing (DON) on December 3, 2013, at 8:35 a.m., in the 200 hall medication room revealed twelve Ondanestron (antiemetic medication) 4 mg tablets with an expiration date of November 30, 2013, and three Warfarin (blood thinner) 6 mg tablets with an expiration date of August 30, 2012.</p> <p>Review of facility policy, Medication Storage In The Facility, revealed "...13. Outdated...medications...are immediately removed from stock, disposed of according to procedures for medication destruction..."</p> <p>Interview with the DON on December 3, 2013, at 3:40 p.m., confirmed the facility had failed to dispose of all outdated medications.</p>	F 431	<p>3. All nursing staff will be re-educated by the Director of Nursing or RN Supervisor regarding expired medication policy and monitoring by 12/23/13.</p> <p>4. The Director of Nursing or RN Supervisor will audit the medication carts and medication rooms for expired medications 1 time a week for 4 weeks, and then monthly for 2 months. The results of the audits will be reviewed at the Quality Assurance Committee meeting monthly for three (3) months, beginning with the January 2014 QA meeting.</p>	12/23/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445162	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/04/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  ASBURY PLACE AT JOHNSON CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYRTLE AVENUE JOHNSON CITY, TN 37604
--	---

(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 SS=D	<p><b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b></p> <p>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.</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>	F 441	<p><b>F 441 – Infection Control, Prevent Spread, Linens</b></p> <ol style="list-style-type: none"> <li>Resident # 43's foley drainage bag was readjusted off the floor in the dining room by RN # 1 on 12/3/13.</li> <li>All other residents with foley drainage bags were inspected to ensure they were not touching the floor by the Director of Nursing and RN # 1 on 12/3/13.</li> <li>All nursing staff will be re-educated by the Director of Nursing or RN Supervisor regarding infection control and foley bag placement by 12/23/13.</li> </ol>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445162	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/04/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  ASBURY PLACE AT JOHNSON CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYRTLE AVENUE JOHNSON CITY, TN 37604
--	---

(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 7</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure infection control was maintained for one (#43) of six indwelling catheter drainage bags.</p> <p>The findings included:</p> <p>Observation on December 3, 2013, at 8:00 a.m., in the main dining room revealed resident #43 sitting in a geri chair with a covered indwelling catheter drainage bag lying on the floor underneath the seat.</p> <p>Interview with Registered Nurse (RN) #1 at the time of the observation confirmed the indwelling catheter drainage bag was on the floor and "should not be there."</p> <p>Interview with the Director of Nursing (DON) on December 4, 2013, at 10:35 a.m., in the DON's office confirmed the facility had failed to maintain infection control by placing the indwelling catheter drainage bag on the floor.</p>	F 441	<p>4. The Director of Nursing or RN Supervisor or LPN Charge Nurse will conduct random audits of the resident's with foley catheter drainage bags to ensure they are not touching the floor 1 time a week for 4 weeks and then monthly for 2 months. The results of the audits will be reviewed at the Quality Assurance meeting monthly for three (3) months, beginning with January 2014 QA meeting.</p>	12/23/13
-------	---	-------	--	----------