

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

PRINTED: 06/11/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION <i>Poc #2</i>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445162	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/04/2013
NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT JOHNSON CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYTRIC 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	INITIAL COMMENTS AMENDED SURVEY An investigation of C/O #30764, #30825 and #31367 was conducted May 28-June 3, 2013. No deficiencies were cited for C/O #30825 and #31367. Harm level deficiencies were cited for C/O #30764.	F 000	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.		
F 280 SS=G	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has 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. 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. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of a facility investigation and interview the facility failed	F 280	<u>F-280 Right to participate planning care - revise CP</u> 1. Following Resident #1's allegation of CNA #1, X-rays were obtained. Follow-up treatment was coordinated with attending physician, orthopedic physician, and psych services. Care plan was not able to be updated with 2- person assist prior to Resident #1's discharge from the facility. 2. All residents who require the assistance of two persons for bed mobility have been identified. Care plans for residents requiring assistance of two persons for bed mobility have been reviewed and revised as appropriate. To be completed by 6/6/13. 3. Nursing staff have been re-educated on updating care plans in regards to bed mobility and positioning. New hires and staff absent from the re-education will receive this training upon starting work or returning to work, whichever is applicable. To be completed by 6/6/13.	6/6/13	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Mark de Winter</i>			TITLE <i>Admin's Director</i>		(X6) DATE 6/13/13

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.

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F 280	<p>Continued From page 1</p> <p>to ensure the care plan included two person assist with bed mobility for one (#1) resulting in a fractured wrist of nine residents reviewed. The failure resulted in harm for resident #1.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on July 6, 2010 with diagnoses including Senile Dementia, Anxiety, Hypertension, Amputation (Above the right knee), Osteoarthritis, Peripheral Vascular Disease with history of Gangrene, Encephalopathy, Chronic Renal Disease, Bowel Incontinence, Diabetes and Benign Prostatic Hypertrophy (enlarged prostate) with Chronic Urinary Retention.</p> <p>Medical record review of the significant change Minimum Data Set (MDS) dated August 29, 2012 revealed the resident scored 14/15 on the Brief Interview for Mental Status (BIMS) with intact cognition and required extensive assistance of two persons for bed mobility.</p> <p>Medical record review of a nurse's note dated November 5, 2012 at 8:10 a.m. revealed "...Noted 3 cm (centimeter) bruise on (right) wrist area purple in color & (and) 3-4 cm bruise on (left) thumb & wrist area. (Physician) notified. X-rays ordered..."</p> <p>Medical record review of an x-ray report of the left hand dated November 5, 2012 revealed "...Distal radial cortical irregularity is noted...Distal Radial Non-displaced Fracture is suggested...Mild Osteoarthritis..."</p> <p>Medical record review of a physician's progress</p>	F 280	<p>4. The Director of Nurses and/or designee (Asst. Director of Nurses or MDS coordinator) will audit the bed mobility / positioning care plans of five residents per week for 12 weeks for the inclusion of current bed positioning needs. The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate. To begin with June data at the July Q.A. meeting.</p>	

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F 280	<p>Continued From page 2</p> <p>note dated November 5, 2012 revealed "...currently with erythema marks on the wrist...according to patient CNA (Certified Nursing Assistant) held...wrist and tried to make (resident) eat. Patient states wrist are okay....bilateral tenderness..."</p> <p>Medical record review of a bone density study dated November 7, 2012 revealed a "T" score (standard measurement used to interpret the results of a bone mineral density test) of - (minus) 2.5 with an interpretation of Osteoporosis (reduction in bone mass).</p> <p>Review of the facility investigation timeline dated November 8, 2012 revealed the Director of Nursing (DON) interviewed the resident after the resident reported to Certified Nursing Assistant (CNA) #4 that another CNA (#1) had "...held both of (resident's) wrists and strong armed...and forced...to eat." Continued review of the investigation revealed the resident stated to the DON "...a tall CNA...grabbed and held my arms...noted to have purple petchial (petechial) bruising on right and left inner hands and wrist areas..."</p> <p>Interview on May 29, 2013 at 9:30 a.m. in the conference room with the DON revealed when CNA #1 was interviewed by the DON, CNA #1 denied the allegation.</p> <p>Telephone interview on May 31, 2013 at 8:55 a.m. with CNA #1 denied the CNA tried to force the resident to eat a banana. Continued interview confirmed CNA #1 "lifted (resident) improperly when pulling (resident) up in bed. (Resident) was double amputee (Medical record review revealed</p>	F 280			

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F 280	<p>Continued From page 3</p> <p>the resident was actually a single amputee above the right knee). I went to the head of the bed...had (resident) cross arms...across chest. There was no draw sheet on the bed. My hands were over (resident's) hands. My arms were draped across (resident's) shoulders. I pulled (resident) from behind...had moved (resident) that way a dozen times..."</p> <p>Telephone interview on May 30, 2013 at 12:30 p.m. with the Tennessee Bureau of Investigation (TBI) agent who investigated the injury to resident #1 confirmed the agent had interviewed CNA #1 and the CNA confirmed performing an inappropriate repositioning of the resident (night shift November 4-5, 2012).</p> <p>Telephone interview on May 31, 2013 at 12:50 p.m. with CNA #1 revealed CNA #1 asked another CNA to assist with pulling resident #1 up in bed, but the CNA "said...didn't have time..." Continued interview with CNA #1 confirmed the following: The resident "usually had a draw sheet...that night having to change sheets more often...removed draw sheet from the bed and did not have another draw sheet with me...(resident) was full assist...requires two people...I was in a hurry...trying to get things done...was a complete accident...did the wrong thing trying to move (resident) up by myself...should have gotten someone to help me...didn't know he had a bone disease..."</p> <p>Telephone interview and medical record review with the MDS Coordinator on May 31, 2013 at 2:05 p.m. confirmed the resident was assessed on August 29, 2012 as requiring two-person assist with bed mobility. Continued interview</p>	F 280		

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F 280	Continued From page 4 needs for bed mobility or transfer requirements. Continued interview confirmed the care plan for the resident did not include the requirement for two-person assist with bed mobility.	F 280		
F 282 SS=D	<p>C/O #30764 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, review of personnel files and interview, the facility failed to provide incontinence care for one (#8) of nine residents reviewed.</p> <p>The findings included: Resident #8 was admitted to the facility on May 19, 2012 with diagnoses including Cerebrovascular Accident (Stroke) resulting in Left Hemiparesis (weakness), Coronary Artery Disease with history of Coronary Artery Bypass Graft, history of Ischemic Colitis, Hypertension, Severe Cardiomyopathy and Benign Prostatic Hypertrophy (enlarged prostate).</p> <p>Medical record review of a quarterly Minimum Data Set (MDS) dated August 22, 2012 revealed the resident scored 5/15 on the Brief Interview for Mental Status (BIMS) with severe cognitive impairment; required extensive assistance of two</p>	F 282	<p><u>F-282 Services by qualified persons/per care plan</u></p> <ol style="list-style-type: none"> 1. Upon discovery of Resident #8's incontinence care needs on 8/31/12, appropriate peri-care was performed by CNA #2 and LPN #1. Upon discovery of Resident #8's incontinence care needs on 11/5/12, appropriate peri-care was provided by CNA #1, as directed by LPN #2. Resident #8 has maintained skin integrity. 2. Residents who are incontinent of bowel and/or bladder have been identified and care plans have been reviewed and updated accordingly. 3. Nursing staff will be re-educated on appropriate and timely incontinence care. New hires and staff absent from the re-education will receive this training upon starting work or returning to work, whichever is applicable. To be completed by 6/6/13. 4. The Nursing Supervisor or designated Charge Nurse will randomly check 3 incontinent residents per day for 4 weeks and then 1 resident per day for 8 weeks to ensure appropriate and timely incontinent care has been provided. The results of the audits will be reviewed at the Quality Assurance Committee (QAC), Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as 	6/6/13

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F 282	<p>Continued From page 5</p> <p>for bed mobility and transfers; required extensive assistance with dressing; was totally dependent on staff for hygiene and bathing; required assistance with moving from a seated to a standing position, moving on and off the toilet and surface-to-surface transfers; and was incontinent of bowel and bladder.</p> <p>Medical record review of the care plan updated August 15, 2012 revealed the resident was at risk for impaired skin integrity related to decreased mobility and bowel incontinence. Continued review revealed "Provide incontinence care following incontinent episodes...Calmoseptine (multipurpose moisture barrier) PRN (as needed) to buttocks..."</p> <p>Review of the personnel file (investigation for allegation of abuse) for Certified Nursing Assistant (CNA) #1 (terminated from the facility on November 6, 2012) revealed Licensed Practical Nurse (LPN) #1 documented a "written warning" dated August 31, 2012 at 9:30 p.m. for CNA #1. Continued review of the disciplinary action revealed (Resident #8)...so wet (with bowel movement (BM)) brief fell apart-skin gauled (gauled-rash caused by wetness)...Full bed (symbol for change)...BM all over scrotum gauled (gauled)..."</p> <p>Continued review of the personnel file for CNA #1 revealed a second written warning was issued by LPN #2 on November 5, 2012 and noted "... (Resident #8) was wet. Resident was not changed or position changed in 5 hrs. (hours)..."</p> <p>Telephone interview on May 29, 2013 at 5:50 p.m. with LPN #1 confirmed CNA #1 and LPN #1</p>	F 282	appropriate. To begin with June data at the July Q.A. meeting.	

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F 282	<p>Continued From page 6</p> <p>worked the evening shift on August 31, 2012 and confirmed CNA #1 was assigned to resident #8. Continued interview confirmed when LPN #1 checked (resident #8), the resident was "so wet" the brief fell apart and confirmed dried BM and gaulding on the scrotum. Continued interview revealed the LPN "Stopped my treatments and my meds (medication pass)" and confirmed "me and the oncoming CNA (#3)" provided incontinence care and a full bed change for the resident. Continued interview confirmed LPN #1 "...knew rounds had not been done. There's a noticeable difference in just having changed someone and it (urine and feces) being there a long time. It was noticeable."</p> <p>Telephone interview on May 29, 2013 at 6:13 p.m. with CNA #3 (who relieved CNA #1 on August 31, 2012) confirmed "It was evident...hadn't been changed for hours."</p> <p>Telephone interview on May 29, 2013 at 6:55 p.m. with LPN #2 confirmed LPN #2 documented the written warning (#2) for CNA #1 on November 5, 2013. LPN #2 confirmed CNA #1 worked the night shift (same shift as LPN #2) on November 5, 2013. LPN #2 stated, "I marked the pad and the brief (for resident #8)...went back (after) five hours and they (pad and brief) had not been changed. (Resident) was wet."</p>	F 282		
F 309 SS=G	<p>C/O #30764</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,</p>	F 309		

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F 309	<p>Continued From page 7</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility investigation, review of the facility staffing schedule and interview, the facility failed to ensure appropriate procedures were used in repositioning one resident (#1) in the bed and failed to provide incontinence care for one resident (#8) of nine residents reviewed. The facility's failure resulted in harm for resident #1.</p> <p>Resident #1 was admitted to the facility on July 6, 2010 with diagnoses including Senile Dementia, Anxiety, Hypertension, Amputation (Above the right knee), Osteoarthritis, Peripheral Vascular Disease with history of Gangrene, Encephalopathy, Chronic Renal Disease, Bowel Incontinence, Diabetes and Benign Prostatic Hypertrophy (enlarged prostate) with Chronic Urinary Retention. Resident #1 was discharged to and expired in the hospital on May 18, 2013.</p> <p>Medical record review of the significant change Minimum Data Set (MDS) dated August 29, 2012 revealed the resident scored 14/15 on the Brief Interview for Mental Status (BIMS) with intact cognition; required extensive assistance of two persons for bed mobility; was totally dependent</p>	F 309	<p><u>F-309 Provide care and services for highest well-being</u></p> <ol style="list-style-type: none"> Following Resident #1's allegation of CNA #1, X-rays were obtained. Follow-up treatment was coordinated with attending physician, orthopedic physician, and psych services. Additionally, an investigation was immediately initiated, including suspension of CNA #1. Facility's investigation resulted in termination of CNA #1 on 11/6/12. <p>Upon discovery of Resident #8's incontinence care needs on 8/31/12, appropriate peri-care was performed by CNA #2 and LPN #1. CNA #1 received a written performance warning for the 8/31/12 incident. Upon discovery of Resident #8's incontinence care needs on 11/5/12, appropriate peri-care was provided by CNA #1, as directed by LPN #2. A review of Resident #8's skin condition before and after both incidents revealed no change in skin integrity. CNA #1 was initially given a final written warning on 11/5/12, but was subsequently suspended and terminated on 11/6/12 as a result of the investigation.</p> <ol style="list-style-type: none"> All residents who require the assistance of two persons for bed mobility have been identified. Care plans for residents requiring assistance of two persons for bed mobility have been reviewed and revised as appropriate. Residents who are incontinent of bowel and/or bladder have been identified, and care plans have been reviewed and updated accordingly. 		

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F 309	<p>Continued From page 8</p> <p>on staff for transfers, dressing and hygiene; had limitations in one lower extremity; was incontinent of bowel; and had an indwelling urinary catheter.</p> <p>Medical record review of a nurse's note dated November 5, 2012 at 8:10 a.m. revealed "...Noted 3 cm (centimeter) bruise on (right) wrist area purple in color & (and) 3-4 cm bruise on (left) thumb & wrist area. (Physician) notified. X-rays ordered..."</p> <p>Medical record review of an x-ray report of the left hand dated November 5, 2012 revealed "...Distal radial cortical irregularity is noted...Distal Radial Non-displaced Fracture is suggested...Mild Osteoarthritis..."</p> <p>Medical record review of a physician's progress note dated November 5, 2012 revealed "...currently with erythema marks on the wrist...according to patient CNA (Certified Nursing Assistant) held...wrist and tried to make (resident) eat. Patient states wrist are okay....bilateral tenderness..."</p> <p>Medical record review of a bone density study dated November 7, 2012 revealed a "T" score (standard measurement used to interpret the results of a bone mineral density test) of - (minus) 2.5 with an interpretation of Osteoporosis (reduction in bone mass).</p> <p>Review of the facility investigation timeline dated November 8, 2012 revealed the Director of Nursing (DON) interviewed the resident after the resident reported to Certified Nursing Assistant (CNA) #4 that another CNA (#1) had "...held both of (resident's) wrists and strong armed...and</p>	F 309	<p>3. Nursing staff will be re-educated on appropriate bed re-positioning techniques as well as providing appropriate and timely incontinence care. New hires and staff absent from the re-education will receive this training upon starting work or returning to work, whichever is applicable. To be completed by 6/6/13.</p> <p>4. The Director of Nursing or designee (Rehab Director, Nursing Supervisor, Charge Nurse, or wound care nurse) will observe CNA staff reposition 2 residents per day for 4 weeks and then 1 resident per day for 8 weeks.</p> <p>Nursing Supervisor or designee (charge nurse or wound care nurse) will randomly check 3 incontinent residents per day for 4 weeks and then 1 resident per day for 8 weeks to determine that appropriate and timely incontinent care has been provided. The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate. To begin with June data at the July Q.A. meeting.</p>	6/6/13

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F 309	<p>Continued From page 9</p> <p>forced...to eat." Continued review of the investigation revealed the resident stated to the DON "...a tall CNA...grabbed and held my arms...noted to have purple petchial (petechial) bruising on right and left inner hands and wrist areas..."</p> <p>Review of the staffing schedule confirmed CNA #1 work 3:00 p.m.-7:00 a.m. November 4-5, 2012.</p> <p>Interview on May 29, 2013 at 9:30 a.m. in the conference room with the DON confirmed CNA #1 was assigned to resident #1 at the time the alleged incident occurred. Continued interview revealed the facility could not "prove" abuse by CNA #1 and revealed an agent from the Tennessee Bureau of Investigation (TBI) and a worker from Adult Protective Services (APS) came to the facility to investigate the allegation CNA #1 held the hands of the resident and tried to force the resident to eat a banana.</p> <p>Telephone interview on May 31, 2013 at 8:55 a.m. with CNA #1 denied the CNA tried to force the resident to eat a banana. Continued interview confirmed CNA #1 "lifted (resident) improperly when pulling (resident) up in bed. (Resident) was double amputee (Medical record review revealed the resident was actually a single amputee above the right knee). I went to the head of the bed...had (resident) cross arms...across chest. There was no draw sheet on the bed. My hands were over (resident's) hands. My arms were draped across (resident's) shoulders. I pulled (resident) from behind...had moved (resident) that way a dozen times..."</p>	F 309		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 C 06/04/2013
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NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT JOHNSON CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYTRLE AVENUE JOHNSON CITY, TN 37604
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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 309	<p>Continued From page 10</p> <p>Telephone interview on May 30, 2013 at 12:30 p.m. with the Tennessee Bureau of Investigation (TBI) agent who investigated the injury to resident #1 confirmed the agent had interviewed CNA #1 and the CNA confirmed performing an inappropriate repositioning of the resident (night shift November 4-5, 2012).</p> <p>Telephone interview on May 31, 2013 at 12:50 p.m. with CNA #1 revealed CNA #1 asked another CNA to assist with pulling resident #1 up in bed, but the CNA "said...didn't have time..." Continued interview with CNA #1 confirmed the following: The resident "usually had a draw sheet...that night having to change sheets more often...removed draw sheet from the bed and did not have another draw sheet with me...(resident) was full assist...requires two people...I was in a hurry...trying to get things done...was a complete accident...did the wrong thing trying to move (resident) up by myself...should have gotten someone to help me...didn't know he had a bone disease..."</p> <p>Telephone interview on May 31, 2013 at 2:15 p.m. with the DON confirmed "Everyone knows you don't pull someone by the arms...(CNA #1) knew...did it improperly and did it anyway."</p> <p>Telephone interview on June 4, 2013 at 10:25 a.m. with the radiologist who read the x-ray film dated November 5, 2013 of the resident's wrist confirmed the type of fracture seen on the x-ray could have been caused by a "squeezing, twisting" motion as described by the CNA (#1).</p> <p>Resident #8 was admitted to the facility on May 19, 2012 with diagnoses including</p>	F 309		
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F 309	<p>Continued From page 11</p> <p>Cerebrovascular Accident (Stroke) resulting in Left Hemiparesis (weakness), Coronary Artery Disease with history of Coronary Artery Bypass Graft, history of Ischemic Colitis, Hypertension, Severe Cardiomyopathy and Benign Prostatic Hypertrophy (enlarged prostate).</p> <p>Medical record review of a quarterly Minimum Data Set (MDS) dated August 22, 2012 revealed the resident scored 5/15 on the Brief Interview for Mental Status (BIMS) with severe cognitive impairment; required extensive assistance of two for bed mobility and transfers; required extensive assistance with dressing; was totally dependent on staff for hygiene and bathing; required assistance with moving from a seated to a standing position, moving on and off the toilet and surface-to-surface transfers; and was incontinent of bowel and bladder.</p> <p>Medical record review of the care plan updated August 15, 2012 revealed the resident was at risk for impaired skin integrity related to decreased mobility and bowel incontinence. Continued review revealed "Provide incontinence care following incontinent episodes...Calmoseptine (multipurpose moisture barrier) PRN (as needed) to buttocks..."</p> <p>Medical record review of a monthly nursing summary dated November 2012 revealed "...Position...Every 2 hours...incontinent..."</p> <p>Review of the facility's policy for abuse and neglect revealed "It is the policy of (facility named) that no abuse, neglect or mistreatment of a resident...will be tolerated...Neglect-failure to provide goods and services necessary to avoid</p>	F 309			

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 C 06/04/2013
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F 309	<p>Continued From page 12 physical harm, mental anguish or mental illness..."</p> <p>Review of the personnel file (investigation of an allegation of abuse) for Certified Nursing Assistant (CNA) #1 (terminated from the facility on November 6, 2012) revealed Licensed Practical Nurse (LPN) #1 documented a "written warning" dated August 31, 2012 at 9:30 p.m. for CNA #1. Continued review of the disciplinary action revealed (Resident #8) "...so wet (with bowel movement) brief fell apart-skin gualded (red skin caused by wetness)...Full bed (symbol for change)...BM all over scrotum gualded (gualded)...This nurse made walking round prior to incoming shift coverage...CNA (#2) had to have help to return resident to dry/safe/dignified condition..." Continued review revealed CNA #1 signed the disciplinary action document.</p> <p>Continued review of the personnel file for CNA #1 revealed a second written warning was issued by LPN #2 on November 5, 2012 and noted "... (Resident #8) was wet. Resident was not changed or position changed in 5 hrs. (hours). Employee had been off the floor several times-ask fellow employees where (CNA #1) was-Staff did not know...Policy: Residents will be changed @ (at) X's (times) charge nurse deems necessary and PRN...Follow directions of charge nurse. Make sure residents are clean & (and) dry..." Continued review revealed the CNA gave a written statement denying the allegation.</p> <p>Continued review of the personnel file for CNA #1 revealed the CNA was suspended by telephone on November 5, 2012 "pending investigation of resident allegation of abuse..." Continued review</p>	F 309		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 13</p> <p>of the personnel file revealed CNA #1 was terminated on November 6, 2012 "...for progressive disciplinary action as evidenced by write ups on 8/31/12 & 11/5/12. Attendance violations...Chronic habitual or excessive lateness or absenteeism..."</p> <p>Review of the staffing schedule confirmed CNA #1 worked 3:00 p.m.-7:00 a.m. (16 hours) November 4-5, 2012.</p> <p>Interview on May 29, 2013 at 2:10 p.m. in the conference room with the Director of Nursing (DON) confirmed CNA #1 had received a written warning on August 31, 2012 for failure to provide incontinence care for resident #8. Continued interview revealed the DON was not informed of the allegations until Monday, September 3, 2012. Continued interview confirmed the DON (in place on November 5, 2012) had not seen the second written warning dated November 5, 2012 until May 29, 2013 (when interviewed by surveyor) at 2:10 p.m.</p> <p>Telephone interview on May 29, 2013 at 5:50 p.m. with LPN #1 confirmed CNA #1 and LPN #1 worked the evening shift on August 31, 2012 and CNA #1 was assigned to resident #8. Continued interview confirmed the written warning was documented by LPN #1 at 9:30 p.m. after CNA #1 left the facility early. CNA #3 relieved CNA #1. Continued interview with LPN #1 confirmed resident #8 was "so wet" the brief fell apart and confirmed dried bowel movement (BM) and gaulding on the scrotum. Continued interview revealed the LPN "Stopped my treatments and my meds (medication pass)" and confirmed "me and the oncoming CNA (#3)" provided</p>	F 309		
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F 309	<p>Continued From page 14</p> <p>incontinence care and a full bed change for the resident. Continued interview confirmed LPN #1 "...knew rounds had not been done. There's a noticeable difference in just having changed someone and it (urine and feces) being there a long time. It was noticeable."</p> <p>Telephone interview on May 29, 2013 at 6:13 p.m. with CNA #3 (who relieved CNA #1 on August 31, 2012) confirmed resident #8 was "in a mess" and confirmed LPN #1 assisted CNA #3 to "clean" the resident. Continued interview confirmed "It was evident...hadn't been changed for hours."</p> <p>Telephone interview on May 29, 2013 at 6:55 p.m. with LPN #2 confirmed LPN #2 documented the second written warning for CNA #1 dated November 5, 2013. Continued interview revealed LPN #2 had ongoing concerns with the lack of care provided by CNA #1. LPN #2 confirmed CNA #1 worked the night shift (same shift as LPN #2) on November 4-5, 2013 and was assigned to resident #8. LPN #2 stated, "I marked the pad and the brief (for resident #8)...went back (after) five hours and they (pad and brief) had not been changed. (Resident) was wet. I told (CNA #1) to go change him...He's sopping wet. I want you to do it now."</p> <p>Telephone interview on May 31, 2013 at 9:10 a.m. with CNA #1 confirmed resident #8 "had constant Diarrhea...always had BM on (resident)..." Continued interview revealed CNA #1 denied failure to provide incontinence care for 5 hours.</p>	F 309		
F 312 SS=G	<p>C/O #30764</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p>	F 312		

445162

A. BUILDING _____

C

B. WING _____

06/04/2013

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
TAGSUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)ID
PREFIX
TAGPROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
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DEFICIENCY)(X5)
COMPLETION
DATE

F 312

Continued From page 15

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, facility policy review, review of staffing schedules, review of personnel files and interview, the facility failed to ensure staff turned/repositioned and checked for incontinence episodes every two hours for one resident (#8) of nine residents reviewed.

Resident #8 was left unattended for five hours. The facility's failure resulted in harm for resident #8.

Resident #8 was admitted to the facility on May 19, 2012 with diagnoses including Cerebrovascular Accident (Stroke) resulting in Left Hemiparesis (weakness), Coronary Artery Disease with history of Coronary Artery Bypass Graft, history of Ischemic Colitis, Hypertension, Severe Cardiomyopathy and Benign Prostatic Hypertrophy (enlarged prostate).

Medical record review of a quarterly Minimum Data Set (MDS) dated August 22, 2012 revealed the resident scored 5/15 on the Brief Interview for Mental Status (BIMS) with severe cognitive impairment; required extensive assistance of two for bed mobility and transfers; required extensive assistance with dressing; was totally dependent on staff for hygiene and bathing; required assistance with moving from a seated to a

F 312
12

F-312 ADL care provided for dependent residents

1. Upon discovery of Resident #8's incontinence care needs on 8/31/12, appropriate peri-care was performed by CNA #2 and LPN #1. CNA #1 received a written performance warning for the 8/31/12 incident. Upon discovery of Resident #8's incontinence care needs on 11/5/12, appropriate peri-care was provided by CNA #1, as directed by LPN #2. A review of Resident #8's skin condition before and after both incidents revealed no change in skin integrity. CNA #1 was initially given a final written warning on 11/5/12, but was subsequently suspended and terminated as a result of the investigation.
2. Residents who require assistance with incontinence care have been identified.
3. All staff to be re-educated on timely incontinence care. To be completed by 6/6/13. CNAs will complete peri-care competency and bed positioning/mobility competency by 6/14/13. During orientation, new hire CNAs will have education and competency on peri-care and bed reposition/mobility. Staff absent from the re-education will receive this training upon returning to work.
4. The Director of Nursing or designee (Rehab Director, Nursing Supervisor, Charge Nurse, or wound care nurse) will observe CNA staff reposition 2 residents per day for 4 weeks and then 1 resident per day for 8 weeks.

6/14/13

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NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT JOHNSON CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYRTLE AVENUE JOHNSON CITY, TN 37604
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F 312	<p>Continued From page 16</p> <p>standing position, moving on and off the toilet and surface-to-surface transfers; and was incontinent of bowel and bladder.</p> <p>Review of the facility's policy for abuse and neglect revealed "It is the policy of (facility named) that no abuse, neglect or mistreatment of a resident...will be tolerated...Neglect-failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness..."</p> <p>Medical record review of the care plan updated August 15, 2012 revealed the resident was at risk for impaired skin integrity related to decreased mobility and bowel incontinence. Continued review revealed "Provide incontinence care following incontinent episodes...Calmoseptine (multipurpose moisture barrier) PRN (as needed) to buttocks..."</p> <p>Medical record review of a monthly nursing summary dated November 2012 revealed "...Position...Every 2 hours...incontinent..."</p> <p>Review of the personnel file (Investigation of an allegation of abuse) for Certified Nursing Assistant (CNA) #1 (terminated from the facility on November 6, 2012) revealed Licensed Practical Nurse (LPN) #1 documented a "written warning" dated August 31, 2012 at 9:30 p.m. for CNA #1. Continued review of the disciplinary action revealed (Resident #8) "...so wet (with bowel movement) brief fell apart-skin gauled (red skin caused by wetness)...Full bed (symbol for change)...BM all over scrotum gauled (gauled)...This nurse made walking round prior to incoming shift coverage...CNA (#2) had to have</p>	F 312	<p>The Director of Nursing or designee (Nursing Supervisor, charge nurse, or wound care nurse) will randomly check 3 incontinent residents per day for 4 weeks and then 1 resident per day for 8 weeks to determine that appropriate and timely incontinent care has been provided. The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate. To begin with June data at the July Q.A. meeting.</p>	

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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 312	<p>Continued From page 17 help to return resident to dry/safe/dignified condition..." Continued review revealed CNA #1 signed the disciplinary action document.</p> <p>Continued review of the personnel file for CNA #1 revealed a second written warning was issued by LPN #2 on November 5, 2012 and noted "... (Resident #8) was wet. Resident was not changed or position changed in 5 hrs. (hours). Employee had been off the floor several times-ask fellow employees where (CNA #1) was-Staff did not know...Policy: Residents will be changed @ (at) X's (times) charge nurse deems necessary and PRN...Follow directions of charge nurse. Make sure residents are clean & (and) dry..." Continued review revealed the CNA gave a written statement denying the allegation.</p> <p>Continued review of the personnel file for CNA #1 revealed the CNA was suspended by telephone on November 5, 2012 "pending investigation of resident allegation of abuse..." Continued review of the personnel file revealed CNA #1 was terminated on November 6, 2012 "...for progressive disciplinary action as evidenced by write ups on 8/31/12 & 11/5/12. Attendance violations...Chronic habitual or excessive lateness or absenteeism..."</p> <p>Review of the staffing schedule confirmed CNA #1 worked 3:00 p.m.-7:00 a.m. (16 hours) November 4-5, 2012.</p> <p>Interview on May 29, 2013 at 2:10 p.m. in the conference room with the Director of Nursing (DON) confirmed CNA #1 had received a written warning on August 31, 2012 for failure to provide incontinence care for resident #8. Continued</p>	F 312			

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NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT JOHNSON CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST MYRTLE AVENUE JOHNSON CITY, TN 37804		
(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 312	<p>Continued From page 18</p> <p>interview revealed the DON was not informed of the allegations until Monday, September 3, 2012. Continued interview confirmed the DON (in place on November 5, 2012) had not seen the second written warning dated November 5, 2012 until May 29, 2013 (when interviewed by surveyor) at 2:10 p.m.</p> <p>Telephone interview on May 29, 2013 at 5:50 p.m. with LPN #1 confirmed CNA #1 and LPN #1 worked the evening shift on August 31, 2012 and CNA #1 was assigned to resident #8. Continued interview confirmed the written warning was documented by LPN #1 at 9:30 p.m. after CNA #1 left the facility early. CNA #3 relieved CNA #1. Continued interview with LPN #1 confirmed resident #8 was "so wet" the brief fell apart and confirmed dried bowel movement (BM) and gaulding on the scrotum. Continued interview revealed the LPN "Stopped my treatments and my meds (medication pass)" and confirmed "me and the oncoming CNA (#3)" provided incontinence care and a full bed change for the resident. Continued interview confirmed LPN #1 "...knew rounds had not been done. There's a noticeable difference in just having changed someone and it (urine and feces) being there a long time. It was noticeable."</p> <p>Telephone interview on May 29, 2013 at 6:13 p.m. with CNA #3 (who relieved CNA #1 on August 31, 2012) confirmed resident #8 was "in a mess" and confirmed LPN #1 assisted CNA #3 to "clean" the resident. Continued interview confirmed "It was evident...hadn't been changed for hours."</p> <p>Telephone interview on May 29, 2013 at 6:55 p.m. with LPN #2 confirmed LPN #2 documented the</p>	F 312			

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NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT JOHNSON CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 106 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 312	Continued From page 19 second written warning for CNA #1 dated November 5, 2013. Continued interview revealed LPN #2 had ongoing concerns with the lack of care provided by CNA #1. LPN #2 confirmed CNA #1 worked the night shift (same shift as LPN #2) on November 4-5, 2013 and was assigned to resident #8. LPN #2 stated, "I marked the pad and the brief (for resident #8)...went back (after) five hours and they (pad and brief) had not been changed. (Resident) was wet. I told (CNA #1) to go change him...He's sopping wet. I want you to do it now." Telephone interview on May 31, 2013 at 9:10 a.m. with CNA #1 confirmed resident #8 "had constant Diarrhea...always had BM on (resident)..." Continued interview revealed CNA #1 denied failure to provide incontinence care for 5 hours.	F 312		
F 498 SS=G	C/O #30764 483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility investigation, review of facility staffing schedules, review of facility policy, review of personnel files and interview, the facility failed to ensure one Certified Nursing Assistant (CNA #1) was competent to provide care for two residents	F 498	<u>F-498 Nurse Aide demonstrate competency/care needs</u> 1. Following Resident #1's allegation of CNA #1, X-rays were obtained. Follow-up treatment was coordinated with attending physician, orthopedic physician, and psych services. Additionally, an investigation was immediately initiated, including suspension of CNA #1. Facility's investigation resulted in termination of CNA #1 on 11/6/12. Upon discovery of Resident #8's incontinence care needs on 8/31/12, appropriate peri-care was performed by CNA #2 and LPN #1. CNA #1 received a written performance warning for the 8/31/12 incident. Upon discovery of Resident #8's incontinence care needs on 11/5/12, appropriate peri-care was provided by CNA #1, as directed by LPN #2. A review of Resident #8's skin condition before and after both incidents revealed no change in skin integrity. CNA #1 was initially given a final written warning on 11/5/12, but was subsequently suspended and terminated on 11/6/12 as a result of the investigation. 2. Residents who require assistance with bed mobility and/or incontinence care have been identified. 3. Nursing staff will be re-educated on appropriate bed re-positioning techniques as well as providing appropriate and timely incontinence care. To be completed by 6/6/13. CNAs will complete peri-care competency and bed	

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: 445162	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/04/2013
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 498	Continued From page 20 (#1, #8) of nine residents reviewed. The facility's failure resulted in harm to resident #1 and #8. Refer to F-280 Refer to F-309 Refer to F-312	F 498	<p>positioning/mobility competency by 6/14/13. During orientation, new hire CNAs will have education and competency on peri-care and bed reposition/mobility. Staff absent from the re-education will receive this training upon returning to work.</p> <p>4. The Director of Nursing or designee (Rehab Director, Nursing Supervisor, Charge Nurse, or wound care nurse) will observe CNA staff reposition 2 residents per day for 4 weeks and then 1 resident per day for 8 weeks.</p> <p>The Director of Nursing or designee (Nursing Supervisor, charge nurse, or wound care nurse) will randomly check 3 incontinent residents per day for 4 weeks and then 1 resident per day for 8 weeks to determine that appropriate and timely incontinent care has been provided. The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate. To begin with June data at the July Q.A. meeting.</p>	6/4/13	