

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

PRINTED: 02/23/2010  
FORM APPROVED  
OMB NO. 0938-0391

45th 4/104/10

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  02/18/2010
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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 000	INITIAL COMMENTS	F 000	<p>This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal regulations.</p> <p>F 221 – Resident #4 has been reassessed for the use of soft belt and has been reduced to a least restrictive device.</p> <p>All residents with restraints have been re-evaluated to ascertain restraints are appropriate. Residents with restraints will be reviewed at least quarterly to determine if the least restrictive device is being used.</p> <p>All residents have the right to be free from physical restraints imposed for purposes of convenience or discipline, and not required to treat a resident's medical condition.</p>	3/31/10
F 221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide an environment free from physical restraints for one resident (#4) of twenty-three residents reviewed.</p> <p>The findings included:</p> <p>Resident #4 was admitted to the facility on July 3, 2006, with diagnoses including Depression, Dementia, Alzheimer's disease with aggressive behavior, Femur Fracture, Hypertension, Hypothyroidism, and Anemia. Medical record review of the minimum data set dated January 18, 2010, revealed the resident had a loss in short and long term memory, severely impaired cognitive skills for daily decision making, required total care with all activities of daily living, had experienced no falls, and required the use of a physical restraint on a daily basis.</p>	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Mary Deborah Hubbard* TITLE: *Executive Director* (X6) DATE: *3/2/10*

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 221	<p>Continued From page 1</p> <p>Medical record review of a Physical Restraint Consent Form, dated October 6, 2006, revealed, "recommending...Blue Belt Restraint (soft belt) be used to treat dementia - poor safety awareness...telephone consent..." by the Power of Attorney (POA).</p> <p>Medical record review of Fall Risk Assessments dated August 6, October 27, 2009 and January 21, 2010, revealed, "...no falls in the last 180 days..."</p> <p>Medical record review of a Physical Restraint Elimination Assessment dated July 28, 2009, revealed, "...resident has not attempted to stand, tugs at belt at times..." Medical record review of a Physical Restraint Elimination Assessment dated October 27, 2009, revealed, "...Continue current POC (plan of care)...no changes in resident status..." Medical record review of a Physical Restraint Elimination Assessment dated January 21, 2010, revealed, "...Continue current POC..." Medical record review of the nurse's notes dated December 2008 through February 18, 2010, physical restraint elimination assessment, and the current care plan revealed no documentation of any attempts to reduce the soft belt restraint to a less restrictive device.</p> <p>Observation on February 16, 2010 at 1:45 p.m., in the hall by the nurse's station revealed the resident sitting in a wheelchair with a soft (blue) belt restraint across the resident's waist and anchored to the back of the wheelchair.</p> <p>Observation on February 17, 2010 at 12:35 p.m., in the hallway revealed the resident in the wheelchair, soft (blue) belt restraint in place, and pulling on the hand rail to propel the resident and</p>	F 221	<p>Nursing staff will be re-educated on the use of restraints and alternatives.</p> <p>DON or Designee will perform audits of resident records with restraints, to determine if restraint evaluations have been completed. Audits will be performed monthly for three (3) months and then a quarterly audit.</p> <p>The results of the audits will be reviewed at the Quality Assurance Committee meeting monthly for three (3) months and recommendations made as appropriate</p>	3/31/10	

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F 221	Continued From page 2 the wheelchair in the hallway.	F 221			
F 226 SS=D	<p>Interview with the director of nursing on February 17, 2010, at 3:00 p.m., in the director of nursing office confirmed the resident had not experienced falls and there had been no trial reductions of the soft (blue) belt restraint for the resident.</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, and interview the facility failed to report an injury of unknown origin to the State Agency as required for one resident (#6) of twenty-three residents reviewed.</p> <p>The findings included:</p> <p>Resident #6 was admitted to the facility on February 23, 2004, with diagnoses including Hypothermia, Hypertension, Cellulitis. Medical record review of the Minimum Data Set (MDS) dated October 5, 2009, revealed the resident had difficulty with long and short term memory, and severe difficulty with decision making skills. Continued medical record review of the MDS revealed the resident required a two person transfer.</p> <p>Medical record review of a nurse's note dated November 19, 2009, at 2:10 p.m., revealed</p>	F 226	<p>F 226 - Resident #6 was discussed with the State Surveyors. Investigation has been completed to ascertain cause of injuries.</p> <p>All residents with injuries of unknown origin will be reported to the appropriate state agencies.</p> <p>The DON and Administrator has reviewed and revised, as appropriate, the policy and procedure regarding abuse and neglect.</p> <p>Staff has been re-educated on the Abuse and Neglect policy and procedures.</p> <p>The Director of Nursing will audit all incident reports with injuries to determine if procedures are followed according to the policy. Audits will be performed weekly for four (4) weeks, monthly for three (3) months.</p>	3/31/10	

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F 226	<p>Continued From page 3</p> <p>"...Called to resident's room by CNA (Certified Nursing Assistant) (#4) pointed out that resident c/o (complained when (the CNA) touched (the resident's) (L) (left) leg...is rotated out, swollen firm (from) thigh down to area just above ankle. Discoloration noted to anterior lower leg &amp; lg. (large) bruise noted to posterior &amp; (and) lateral aspect of (L) thigh. Resident's leg is painful to touch. Orders obtained for x-rays of (L) hip, (L) femur, (L) knee (L) tibia &amp; (L) fibula. (Radiology) notified..."</p> <p>Medical record review of the X-ray report dated November 19, 2009, revealed, "...There is a spiral fracture of the midshaft of the left femur..."</p> <p>Review of the facility policy for Abuse/Neglect or Mistreatment revealed, "...Don (director of nursing) or designee to notify the police, TBI (Tennessee Bureau of Investigation), Adult Protective Services and the State survey and Certification agency in accordance with Federal/State regulations..."</p> <p>Interview with CNA #3 on February 17, 2010, at 10:35 a.m., in the lobby, revealed the resident was given a shower by CNA #3, (with assistance of another CNA) on November 16, 2009, and did not notice any problems with the resident's lower extremities.</p> <p>Interview with CNA #4, on February 17, 2010, at 12:35 p.m., by phone, revealed: "The resident could stand and pivot before the incident with a one person transfer...(the resident) had stayed in bed all day the day before (the incident) due to being sick. I had changed the resident's brief two times in the morning and was going to change the resident's brief again before leaving for the day. I</p>	F 226	<p>The results of the audits will be reviewed at the Quality Assurance Committee meeting monthly for three (3) months and recommendations made as appropriate.</p>	3/31/10
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F 226	Continued From page 4 noticed the resident's left leg shorter than the right leg, and thought the resident needed range of motion to help with 'maybe cramping' and that the resident needed to exercise some. I did range of motion on the right leg then started to exercise the left leg, when I noticed the leg was not right. I went and got the nurse, who came and checked the resident. They got an x-ray and sent the resident to the hospital."  Interview with Licensed Practical Nurse (LPN #1) on February 17, 2010, at 9:40 a.m., in the lobby, revealed at approximately 2:00 p.m., on November 19, 2009, CNA #4 went in to do "dry rounds" (Perineal care), and noticed a bruise on the resident's left thigh, and the left leg shorter than the right leg. Continued interview revealed LPN #1 and the Registered Nurse (in charge) assessed the resident and a mobile x-ray done. LPN #1 stated the x-ray was positive for a fracture of the left leg and the resident was sent to the hospital and admitted.  Interview with the Director of Nursing (DON) on February 18, 2010, at 9:00 a.m., in the DON's office, confirmed the facility failed to report the injury of unknown origin to the state agency.	F 226			
F 272 SS=D	C/O #24533 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the RAI	F 272	F 272 – Resident #2 has been reassessed and RAI updated to reflect assessment.  All residents will have an accurate comprehensive assessment of the residents needs.		3/31/10

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F 272	<p>Continued From page 5 specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Contenance; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to provide a comprehensive and accurate assessment for one resident (#2) of twenty-three residents reviewed.</p> <p>The findings included:</p> <p>Resident #2 was admitted to the facility on April 4, 2008, with diagnoses including Alzheimer's Dementia, and Hypertension.</p> <p>Medical record review of Wound Documentation dated January 14, 2010, and February 4, 2010,</p>	F 272	<p>Care plan staff have been re-educated on the process for completing a comprehensive assessment accurately.</p> <p>The Director of Nursing or Designee will audit (10) ten MDS for accuracy. Audits will be performed weekly for four (4) weeks, monthly for three (3) months.</p> <p>The results of the audits will be reviewed at the Quality Assurance Committee meeting monthly for three (3) months and recommendations made as appropriate</p>

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F 272	Continued From page 6 revealed the resident had developed Stage II pressure ulcers on the left and right ankles.  Medical record review of the minimum data set (MDS) dated January 24, 2010, revealed " ...Ulcers ...0 ..."  Interview with LPN #4 (care plan nurse) on February 18, 2010, at 11:30 a.m., at the Nurses Station, confirmed the MDS dated January 24, 2010 was not accurately coded for Stage II pressure ulcers on the resident's right and left ankles.	F 272			
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 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	F 280	F 280 - Resident #3 care plan has been reviewed and updated to reflect the medical needs and current medical condition.  Resident #2 care plan has been reviewed and revised to reflect the medical needs relating pressure ulcers.  All current residents' care plans will be reviewed to ascertain that they have care plan that accurately reflects their current status.  All residents will have a care plan that meets medical, social, nursing, and psychosocial needs.	3/31/10	

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F 280	<p>Continued From page 7</p> <p>by: Based on medical record review and interview, the facility failed to revise the care plan to reflect Contact (isolation) Precautions for one resident (#3) and for two pressure ulcers for resident #2 of twenty-three residents reviewed.</p> <p>The findings included:</p> <p>Resident #3 was admitted to the facility on August 8, 2009, with diagnoses including Hypertension, Dysphagia, and Alzheimer's. Medical record review of lab reports dated November 11, 2009, November 30, 2009, December 21, 2009, and January 19, 2010, revealed "...C DIFFICILE TOX (toxin) POSITIVE ..." (a bacterium that can cause symptoms of diarrhea to life threatening inflammation of the colon).</p> <p>Medical record review of the current care plan revealed no documentation the care plan had been revised to reflect Contact (isolation) Precautions.</p> <p>Interview on February 17, 2010, at 12:30 p.m., with the DON (Director of Nursing) in the DON's office confirmed the facility failed to revise the care plan to include Contact Precautions for resident #3.</p> <p>Resident #2 was admitted to the facility on April 4, 2008, with diagnoses including Alzheimer's, Dementia, and Hypertension.</p> <p>Medical record review of Wound Documentation dated January 14, 2010, and February 4, 2010, revealed the resident had developed Stage II pressure ulcers on the left and right ankles.</p>	F 280	<p>Care plan staff has been re- in serviced by the Director of Nursing on addressing current problem on care plans.</p> <p>DON or Designee will audit ten (10) resident care plans to ascertain that their care plan are accurately reflects their medical, social, nursing and psychosocial needs. Audits will be performed weekly for four (4) weeks, monthly for three (3) months.</p> <p>The results of the audits will be reviewed at the Quality Assurance Committee meeting monthly for three (3) months and recommendations made as appropriate</p>	3/31/10

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F 280	Continued From page 8 Medical record review of the current care plan revealed no documentation of both Stage II pressure ulcers and no documentation of the use of heel protectors to protect the resident's ankles.  Interview with the care plan coordinator (Licensed Practical Nurse #4) on February 18, 2010, at the nurse's station confirmed the facility had failed to update the care plan for the Stage II pressure ulcer on the left ankle on January 14, 2010, and had failed to document the use of heel protectors for resident #2.	F 280			
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview the facility failed to provide pain management during a dressing change resulting in harm for one resident (#2) and failed to follow physician orders for providing nectar thickened liquids for one resident (#1) of twenty-three residents reviewed.  The findings included:  Resident #2 was admitted to the facility on April 4, 2008, with diagnoses including Alzheimer's,	F 309	F 309 - Resident # 2 has been reassessed for pain and appropriate interventions have been implemented.  All residents will be assessed for pain at admission, thereafter, they will be assessed quarterly and when any significant change in condition occurs.  All residents will receive and be provided with the necessary care and service to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance the comprehensive assessment and plan of care.  Nursing staff have been re-educated on pain management program.	3/31/10	

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F 309	<p>Continued From page 9</p> <p>Dementia, Hypertension, Hypothyroidism, and Debility.</p> <p>Medical record review of the minimum data set dated January 24, 2010, revealed the resident had impaired short and long term memory and severely impaired cognitive skills.</p> <p>Medical record review of a Physician's order dated February 2, 2010, revealed, "...cleanse areas on L (left) and R (right) ankle with wound cleanser, apply skin prep to surrounding area, apply hydrocolloid (type of dressing), check area QD (every day) change Q (every) 5-7 days..."</p> <p>Observation on February 17, 2010, at 10:05 a.m., in the resident's room, revealed treatment nurse #1 and Certified Nursing Aide (CNA) # 1 providing a dressing change. Continued observation of the dressing change revealed the resident yelled out "OH" when the treatment nurse applied wound cleanser to the residents Left ankle. Treatment nurse # 1 stated, "(resident) doesn't holler out until right here in the center," referring to the center of the open wound.</p> <p>Further observation of the dressing change revealed treatment nurse #1 completed the dressing change to the left ankle, failed to stop and intervene for pain management, and preceded to the resident's right ankle. Continued observation revealed the resident yelled out "OH" when the treatment nurse applied skin prep to the right ankle. Treatment nurse # 1 stated "I know that hurts"; failed to assess or provide any intervention for pain and continued with the dressing change. Observation revealed the treatment nurse obtained a wound measurement tool from the established clean field and placed</p>	F 309	<p>DON or Designee will audit 10 (ten) records to ascertain that the pain management program has been followed and pain assessment has been completed.</p> <p>All residents will receive appropriate diet consistency to include liquids according to the dietary orders.</p> <p>Nursing staff have been re-educated on diet consistencies and thickened liquids as well as on dysphagia.</p> <p>DON or Designee will audit 10 (ten) records with altered diets to ascertain diet are being followed based on visual audits.</p> <p>Audits will be performed weekly for four (4) weeks, monthly for three (3) months.</p> <p>The results of the audits will be reviewed at the Quality Assurance Committee meeting monthly for three (3) months and recommendations made as appropriate.</p>	3/31/10	

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F 309	<p>Continued From page 10</p> <p>against the right ankle wound resulting in the resident yelling out "Lord have mercy, you stuck my leg."</p> <p>Review of the facility's policy on Pain Management revealed, "...cognitively impaired residents...assessment of resident will be done by observation indicators, such as those described below, but not limited to them...Verbalization-praying, counting...Vocalization-moaning, grunting..."</p> <p>Interview and medical record review with Treatment Nurse # 1 and Charge Nurse # 1 on February 17, 2010, at 10: 20 a.m., at the back hall nursing desk, revealed the resident had not received any scheduled pain medication and had not received any PRN (as needed) medication prior to the dressing change.</p> <p>Further observation and interview with charge nurse # 1 and treatment nurse on February 17, 2010, at 10:30 a.m., revealed Charge Nurse # 1 administered a PRN pain medication to the resident, after completion of dressing change, and stated "I heard (the resident) screaming back there, so I gave (the resident) something."</p> <p>Interview with the facility Administrator and Director of Nursing on February 18, 2010, at 8:30 a.m., in the Administrator's office, confirmed the facility failed to provide pain management resulting in harm for resident #2.</p> <p>Resident #1 was admitted to the facility on</p>	F 309			

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

PRINTED: 02/23/2010  
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  02/18/2010
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F 309	<p>Continued From page 11</p> <p>November 5, 2009, with diagnoses including Chronic Lymphocytic Leukemia, Pacemaker, CAD (Coronary Artery Disease), Dementia, and Chronic Anemia.</p> <p>Medical record review of a Transfer Summary and Physician Orders dated November 5, 2009, revealed "...Diet Order: Dysphagia (difficulty swallowing) advanced with nectar thick liquids..."</p> <p>Medical record review of a Speech Therapy Progress Note dated December 14, 2009, revealed "...Pt (patient) admitted to skilled ST (speech) services per dysphagia due to pt high risk for choking, aspiration...upon assessment, pt receiving puree, nectar liquids...modified barium swallow study revealed aspiration during thin trial...nectar trials showed no laryngeal penetration...remained on nectar liquids..."</p> <p>Medical record review of a Dietary Progress Note dated February 8, 2010, revealed "...S: Nutritional care plan reviewed, visited for preference, Res (resident) appeared very confused, a CNA (Certified Nursing Assistant) had just gave him a drink of reg (regular) liquids &amp; (and) (resident) couldn't stop coughing. I explained to (CNA) that (resident) needs to always have thickened liquids, because (resident) aspirates on reg liquids, Res is fed by staff. O: Mechanical soft diet with nectar thickened liquids..."</p> <p>Medical record review of the Nurse's Notes dated February 15, 2010, 9:00 a.m., revealed "...Resident (with increased) lethargy today...February 15, 2010, 12:00 p.m., continues to have (increased) lethargy today...February 16, 2010, 9:45 a.m., CXR (chest x-ray) ordered...monitor closely..."</p>	F 309		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/23/2010  
FORM APPROVED  
OMB NO. 0938-0391

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F 309	Continued From page 12	F 309		
	<p>Medical record review of the Physician's Telephone Order dated February 16, 2010, 9:45 a.m., revealed "...Please obtain CXR d/t (due to congestion/cough..."</p> <p>Medical record review of the CXR dated February 16, 2010, revealed "...Clinical Information: Cough, congestion; Impression: Inflammatory and basilar infiltrate may co-exist and cannot be excluded..."</p> <p>Interview with the CDM (Certified Dietary Manager) on February 17, 2010 at 12:50 p.m., in the front lobby confirmed the CDM witnessed the CNA administer regular liquids to the resident as documented in the February 8, 2010 Dietary Progress Note. The CDM stated "...In my opinion he aspirated..." Further interview with the CDM on February 18, 2010 at 10:05 a.m., at the Nurse's Station confirmed the facility failed to provide nectar thick liquids as ordered by the physician.</p>			
F 314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation,</p>	F 314	<p>F 314 – Resident #2 pressure ulcers have been reassessed by the physician/NP and documented in the medical record.</p> <p>Procedures will be followed so that all residents admitted to the facility will avoid development of pressure ulcers unless the clinical condition demonstrates that pressure ulcers were unavoidable. Residents with pressure sores will receive necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.</p> <p>Nursing staff has been re-educated on wound management program.</p>	3/31/10

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

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F 314	<p>Continued From page 13 and interview, the facility failed to prevent the development of an avoidable pressure ulcer resulting in harm for one resident (#2) of twenty-one residents reviewed.</p> <p>The findings included:</p> <p>Resident #2 was admitted to the facility on April 4, 2008, with diagnoses including Alzheimer's, Dementia, and Hypertension. Medical record review of the minimum data set dated January 24, 2010, revealed the resident with a loss in short and long term memory, severely impaired cognitive skills for daily decision making, required extensive to total assistance with activities of daily living, and had no skin breakdown.</p> <p>Medical record review of a lab report dated October 6, 2009, revealed "...albumin (protein for healing) 2.9 (normal value is 2.9 - 4.5)..."</p> <p>Medical record review of a Braden Risk Assessment (risk for development of pressure ulcers) dated November 3, 2009, revealed "16 (high risk for breakdown)."</p> <p>Medical record review of a dietary note dated December 14, 2009, revealed "...res. (resident) appetite poor...at risk for...skin breakdown related to poor appetite...will con't (continue) to receive super cereal and shake for extra calories and protein..."</p> <p>Medical record review of a skin assessment dated January 7, 2010, revealed "...clear...dry..."</p> <p>Medical record review of a skin assessment dated January 14, 2010, revealed "...noted to have area to (L) (left) outer aspect of ankle...scabbed..."</p> <p>Medical record review of</p>	F 314	<p>DON or Designee will audit 10% of the residents with pressure sores to ascertain the wound management program is being implemented.</p> <p>Audits will be performed weekly for four (4) weeks, monthly for three (3) months.</p> <p>The results of the audits will be reviewed at the Quality Assurance Committee meeting monthly for three (3) months and recommendations made as appropriate</p>	3/31/10

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

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FORM APPROVED  
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NAME OF PROVIDER OR SUPPLIER  <b>ASBURY PLACE AT JOHNSON CITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>105 WEST MYRTLE AVENUE JOHNSON CITY, TN 37604</b>
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F 314	<p>Continued From page 14</p> <p>Wound Documentation dated January 14, 2010, revealed "...Type of wound...Pressure...(L) ankle outer aspect...Length 0.5 cm (centimeter)...Width 0.5 cm...Depth...scab...Drainage Amount None...Surrounding Skin Intact...Undermining None...Tunneling None...Odor None..." Medical record review of a nurse's note dated January 14, 2010, at 2:00 p.m., revealed, "Resident noted to have dime size black area to (L) ankle outer aspect." Medical record review of a physician's order dated January 14, 2010, revealed, "...clean with wound cleanser...pat dry...skin prep area daily...cover with a mini island telfa...change every day and PRN (as needed)...monitor for changes until resolved..."</p> <p>Medical record review of a nurse's note dated February 2, 2010, at 2:26 pm, "Area noted on R (right) ankle, Area noted L (left) ankle area, redness et (and) warm to touch, DON (Director of Nursing) seen area. tx (treatment) applied. MD (Medical Director) paged message left. Daughter notified of areas, spoke c (with) daughter." Medical record review of a nurse's note dated February 3, 2010, at 2:56 p.m., revealed "...L (left) ankle remains warm to touch, slightly reddened...Wound Care Nurse notified, 3-11 shift nurse informed of the above..."</p> <p>Medical record review of a skin assessment dated February 4, 2010, revealed "...(L) ankle lateral aspect with open area...(R) (right) ankle lateral aspect with black area..." Medical record review of the wound care nurse's note dated February 4, 2010, revealed "...(R) ankle noted to have black area...no opening...no drainage...unstageable at this time...no s/s (signs or symptoms) infection noted...dressed with hydrocolloid dressing...some c/o (complained of)</p>	F 314		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/23/2010  
FORM APPROVED  
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F 314	<p>Continued From page 15</p> <p>pain with dressing change..." Medical record review of Wound Documentation dated February 4, 2010, revealed "...Type of wound...Pressure...R (right) ankle outer aspect...Length 0.5 cm (centimeters)...Width 0.5 cm...Depth black area...Eschar 100% (percent)...surrounding Skin Intact...Odor None."</p> <p>Medical record review of the care plan dated February 5, 2010, revealed "...Stage II pressure ulcer...administer tx. (treatment) per MD (Medical Doctor) order...skin assessments per facility protocol...measure wound weekly...notify MD and family of any changes..."</p> <p>Medical record review of a nurse's note dated February 16, 2010, at 2:58 p.m., revealed "...heel protectors applied..."</p> <p>Observation on February 17, 2010, at 10:05 a.m., in the resident's room, revealed treatment nurse #1 and Certified Nursing Aid (CNA) #1 providing a dressing change. Continued observation revealed a Stage II pressure ulcer on the right and left outer ankles, circular in shape with redness and sloughing in the center of each area, approximately one centimeter in diameter. Continued observation revealed the resident complained of pain during the dressing changes.</p> <p>Interview on February 18, 2010, at 10:45 a.m., with the wound care (treatment) nurse (LPN #2) in the dining room revealed the wound care nurse was unsure how the left and right ankle wounds had occurred and "...might have been in the bed from not turning over...or while in the wheelchair when the wheels flip around while (resident) is paddling down the hallway..." Continued interview with the wound care nurse confirmed the two</p>	F 314		

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

PRINTED: 02/23/2010  
FORM APPROVED  
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F 314	Continued From page 16 open areas were from pressure and had asked nursing staff to place "heel protectors while in bed." Continued interview with the wound care nurse confirmed the facility had failed to make any changes to the wheelchair.  Interview on February 18, 2010, at 11:23 a.m., at the nurse's station, with LPN #3 and the wound care nurse (#2) confirmed the facility had failed to place the heel protectors on January 14, 2010, until February 16, 2010, (33 days later) or make any changes to the wheelchair, and confirmed the facility had failed to prevent the development of two pressure ulcers resulting in harm for resident #2.	F 314		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441	F 441 - Resident #2 has been re assessed by MD/NP for infection.  All residents with dressing changes will be done using aseptic technique.  Licensed staff will be re-educated on infection control and dressing changes.  DON/ Nursing Supervisor will visually audit dressing changes to ascertain dressing changes are being done in accordance with the infection control policies and procedures.  Resident # 3 has been placed in isolation in accordance to the infection control	3/31/10

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

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F 441	<p>Continued From page 17</p> <p>(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.</p> <p>(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 medical record review, observation, facility policy review, and interview, the facility failed to follow the facility's policy for Infection Control for two resident's (# 2, #3) of twenty-three residents reviewed.</p> <p>The findings included:</p> <p>Resident # 2 was admitted to the facility on April 4, 2008, with diagnoses including Alzheimer's, Dementia, Hypertension, Hypothyroidism, and Debility.</p> <p>Medical record review of a Physician's order dated February 2, 2010, revealed, "...cleanse areas on L (left) and R (right) ankle with wound cleanser, apply skin prep to surrounding area, apply hydrocolloid (type of dressing), check area QD (every day) change Q (every) 5-7 days..."</p> <p>Observation on February 17, 2010, at 10:05 a.m.,</p>	F 441	<p>practice guidelines and appropriate signage has been displayed to alert staff and visitors.</p> <p>All resident with known or suspected communicable infections will be placed in isolation according to the facilities policy and procedures.</p> <p>Nursing staff will be re-educated on infection control practices relating to contact precautions and isolation.</p> <p>DON will audit all residents with known or suspected microorganisms to ascertain policies and procedures have been followed in accordance with infection control policies and procedures.</p> <p>Audits will be performed weekly for four (4) weeks, monthly for three (3) months.</p> <p>The results of the audits will be reviewed at the Quality Assurance Committee meeting monthly for three (3) months and recommendations made as appropriate.</p>	3/31/10
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	<p>Continued From page 18</p> <p>in the resident's room, revealed treatment nurse #1 and Certified Nursing Aid (CNA) # 1 providing a dressing change. Continued observation revealed treatment nurse # 1 established a clean field, cleaned the wound on the left ankle, removed the soiled gloves, failed to wash hands, applied clean gloves and completed the dressing change to the left ankle.</p> <p>Further observation of the dressing change to the right ankle revealed the treatment nurse removed the soiled dressing, placed soiled gloves on the established clean field, and washed hands. Continued observation revealed the treatment nurse applied clean gloves, removed soiled gloves from the established clean field and with same gloved hands opened a clean dressing and applied the dressing to the resident's right ankle.</p> <p>Continued observation revealed the treatment nurse took the clear non biohazard bag containing the soiled dressings and placed in a clear plastic bag inside the back hall soiled utility room.</p> <p>Review of the facility's policy for Dressing: Hydrocolloid revealed, "...wash hands...Don non-sterile gloves...remove soiled dressing...wash hands...Don clean non-sterile gloves...cleanse wound..."</p> <p>Review of the facility policy for Department Responsibilities Regarding medical waste, "...Discard infectious wastes in a red biohazard bag...seal or tie the red biohazard bag...Discard the sealed/tied red biohazard bag in the biohazard cardboard box..."</p> <p>Interview with the facility Administrator and</p>	F 441		

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

PRINTED: 02/23/2010  
FORM APPROVED  
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F 441	<p>Continued From page 19</p> <p>Director of Nursing on February 18, 2010, at 8:30 a.m., in the Administrator's office, confirmed the facility policy for dressing change and for disposal of infectious waste was not followed.</p> <p>Resident # 3 was admitted to the facility on August 11, 2009, with diagnoses including Alzheimer's Dementia, Depression, Anxiety, Hypertension, Coronary Artery Disease, Hypertension, and Hypothyroidism.</p> <p>Observation on February 16, 2010, at 11:00 a.m., in the resident's room revealed a red isolation barrel.</p> <p>Observation and interview with charge nurse # 1 on February 16, 2010, at 11:05 a.m., outside the resident's room revealed the resident was in contact isolation for Clostridium difficile (a bacterial infection that causes diarrhea) and no signage was on the resident door to alert staff and visitors.</p> <p>Review of the facility policy for contact precautions revealed, "...Contact Precautions must be implemented for residents known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact...Examples of infections requiring Contact Precautions include...Clostridium difficile...Signs used to Alert Staff of Contact Precautions...An orange sign instructing visitors to report to the nurse's station before entering should be placed at the doorway.</p> <p>Interview with Charge Nurse # 1 on February 16, 2010, at 11:07 a.m., outside the resident's room confirmed the facility policy for contact isolation was not followed.</p>	F 441		

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

PRINTED: 02/23/2010  
FORM APPROVED  
OMB NO. 0938-0391

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F 502 SS=D	<p>483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY</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> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain laboratory specimens as ordered by the physician for one resident (#5) of twenty-three residents reviewed.</p> <p>The findings included:</p> <p>Resident #5 was admitted to the facility on May 20, 2008, with diagnoses including Psychosis, Dementia, Alzheimer's, Depressive Disorder, and Hypertension.</p> <p>Medical record review of the physician recapitulation orders dated January 15, 2010, (original order May 20, 2008) revealed laboratory (lab) orders, "...LFT (Liver Function Test) Q (every) 3 MONTHS (Oct, Jan, Apr, July)...BMP (Basic Metabolic Panel) Q 3 MONTHS (Oct, Jan, Apr, July)...Depakote (Depakene) Level Q 3 MONTHS (Oct, Jan, Apr, July)..."</p> <p>Medical record review revealed lab specimens for a LFT, BMP, and Depakene (used for manic episodes or seizures) Level were collected on April 8, 2009, May 1, 2009, May 6, 2009, May 25, 2009, July 13, 2009, September 30, 2009, and October 5, 2009.</p> <p>Interview on February 17, 2010, at 2:30 p.m. with</p>	F 502	<p>F 502 – Resident #5 laboratory tests have been obtained and physician has been notified of results.</p> <p>All resident with laboratory tests ordered specimens will be obtained in a timely manner.</p> <p>Licensed staff have been re-educated on physician orders and carrying them out in a timely manner.</p> <p>DON or Designee will audit 10 (ten) charts to ascertain physician orders are carried out in a timely manner. Audits will be performed weekly for four (4) weeks, monthly for three (3) months.</p> <p>The results of the audits will be reviewed at the Quality Assurance Committee meeting monthly for three (3) months and recommendations made as appropriate.</p>	3/31/10
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/23/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445162</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/18/2010</b>
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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 37604</b>
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F 502	Continued From page 21	F 502		
F 514 SS=D	<p>LPN #3 confirmed the facility had not completed the labs since October 5, 2009.</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to maintain an accurate medical record for one resident (#1) of twenty-three residents reviewed.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on November 5, 2009, with diagnoses including Chronic Lymphocytic Leukemia, Pacemaker, CAD (Coronary Artery Disease), HOH (Hard-of-Hearing), Dementia, and Chronic Anemia.</p> <p>Medical record review of the December 2009, (7-3, 3-11, 11-7) and January 2010, (7-3) ADL (Activity of Daily Living) monthly flow sheet (copy</p>	F 514	<p>F 514 - All residents ADL flow sheet will be completed to reflect care being rendered.</p> <p>Clinical records will contain sufficient information to identify the resident; a record of the resident's assessments; plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Nursing staff has been re-educated on documentation.</p> <p>DON or Designee will audit 10(ten) records to ascertain care is being documented completely and accurately. Audits will be performed weekly for four (4) weeks, monthly for three (3) months.</p> <p>The results of the audits will be reviewed at the Quality Assurance Committee meeting monthly for three (3) months and recommendations made as appropriate</p>	3/31/10

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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 514	Continued From page 22 obtained February 16, 2010, at approximately 2:30p.m.) revealed numerous area on the ADL record no documentation.  Medical record review and a copy of the same ADL flow sheets (December 2009, 7-3, 3-11, 11-7 and January 2010, 7-3) obtained on February 17, 2010 at approximately 3:30 p.m. revealed documentation had been entered into the blanks areas of the December 2009, (7-3, 3-11, 11-7) and January 2010, (7-3) ADL flow sheets.  Interview with Nursing Home Administrator (NHA) on February 18, 2010, at 8:55 a.m., in the Administrative Conference Room confirmed documentation had been added to the ADL flow sheets for the time period of December 2009, (7-3, 3-11, 11-7) and January 2010, (7-3) and the medical record was not accurate.	F 514		