

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

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| (Y1) Provider / Supplier / CLIA / Identification Number 445118 | (Y2) Multiple Construction A. Building B. Wing | (Y3) Date of Revisit 6/20/2011 |
| Name of Facility ASHTON PLACE HEALTH & REHAB CENTER | Street Address, City, State, Zip Code 3030 WALNUT GROVE RD MEMPHIS, TN 38111 | |

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

| (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date |
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| ID Prefix <u>F0323</u> Reg. # <u>483.25(h)</u> LSC _____ | Correction Completed <u>06/08/2011</u> | ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed | ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed |
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| Reviewed By <input checked="" type="checkbox"/> | Reviewed By <u>SP</u> | Date: <u>6/20/11</u> | Signature of Surveyor: <u>[Signature]</u> | Date: <u>6/20/11</u> |
| Reviewed By _____ | Reviewed By _____ | Date: _____ | Signature of Surveyor: _____ | Date: _____ |

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| Followup to Survey Completed on: <u>5/11/2011</u> | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right;"> <tr> <td>YES</td> <td>NO</td> </tr> </table> | YES | NO |
| YES | NO | | |

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: 445118 | (X2) MULTIPLE CONSTRUCTION: A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 05/11/2011 |
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| NAME OF PROVIDER OR SUPPLIER ASHTON PLACE HEALTH & REHAB CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 3030 WALNUT GROVE RD MEMPHIS, TN 38111 |
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| F 323 SS=G | <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #s TN00027448 and TN00027940</p> <p>Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure a safe environment for residents at risk for falls for 7 of 33 (Residents #2, 7, 9, 12, 15, 17 and 30) sampled residents and adequate supervision to prevent elopement for 1 of 33 (Resident #29) sampled residents. The failure of the facility to follow care plan interventions resulted in actual harm when Resident #30 fell with injuries of a 2 centimeter (cm) head laceration and hematoma.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility's "Falls and Fall Risk, Managing" policy documented, "...If falling recurs [reoccurs] despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions..." | F 323 | <p>The statements made on this plan of correct are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, Ashton Place Rehab and Care Center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p>F323 The facility will ensure that the resident environment remains free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents as identified in residents plan of care. The facility will continue to follow its "Falls & Fall Risk Managing" policy documented.... "If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions".</p> <ol style="list-style-type: none"> 1. <ul style="list-style-type: none"> • Resident #30 – the associates involved received one-on-one education on 1/14/11 regarding appropriate safety interventions | 06/08/2011 |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i> LNHA | TITLE CEO/Administrator | (X6) DATE 5-24-11 |
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 323 | Continued From page 1 2. Medical record review for Resident #30 documented an admission date of 1/13/09 with diagnoses of Hypothyroidism, Diabetes Mellitus, Hypertension and Chronic Obstructive Pulmonary Disease. Review of the nurses notes dated 1/3/11 at 6:00 PM documented, "the resident [#30] was on the floor. Resident was found on her knees on the floor next to bed c [with] her hands and head on the bed. Fall was not witnessed." Review of the "Ashton Place Fall Screen" dated 1/4/11 documented the physical therapist performed a therapy screen and documented suggestions that nursing try these strategies and determine if effective: "keep bed in lowest position, siderails up at all times, close supervision when up in gerichair." Review of the of the care plan updated 1/4/11 documented new interventions: "Keep resident in view of staff at all times" and "Resident on q [every] 30 min [minute] checks." Review of the nurses notes dated 1/14/11 at 2:30 PM documented, "resident was observed face down on floor, falling out of geri-chair. Resident was lying on rt. [right] side in front of bedroom door." Review of the nurses notes dated 1/14/11 at 2:40 PM documented the resident was transported via ambulance to the Emergency Room. Review of the "Resident Transfer Form" dated 1/14/11 documented, "Observed resident on floor face down c [with] R [right] side of head large laceration bleeding large hematoma." Review of Resident #30's hospital medical record documented an admission date of 1/14/11 and discharge date of 1/25/11 with diagnoses of Fall, Petechial Hemorrhage in the Right Frontoparietal area, C1 ring Fracture, Dementia, 2 cm Head | F 323 | and monitoring of resident for safety. <ul style="list-style-type: none">Resident #2 – safety devices were immediately implemented on 5/11/11 at 5:18 pm and care plan updated for such. Safety devices are checked for appropriate placement at least each shift and Resident #2 have each safety devices in place as ordered.Resident #7 – Geri-chair reclined to appropriate position on 5/11/11 at 5:18 pm. Care plan and order updated accordingly. The associates involved in care of this resident received one-on-one education on 5/24/11 regarding use of Geri chair for safety intervention for this resident. Safety devices are checked for appropriate placement at least each shift and resident #7 continues to have geri-chair reclined and in appropriate position to ensure safety.Resident #9 the associate involved received one-on-one education on 4/12/11 regarding appropriate transfer techniques and following care plan of such.Resident #12 – Bed bolsters were re-applied to resident on 5/10/11 at 4:20 pm. Safety devices are checked for appropriate placement at least each shift and resident #12 continues to have appropriate safety devices in place. | |

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| F 323 | <p>Continued From page 2</p> <p>Laceration, Spondylosis, Hypothyroidism, Diabetes Mellitus and Neuropathy.</p> <p>The failure of the facility to ensure the care plan intervention to keep the resident in view of the staff at all times resulted in actual harm when Resident #30 fell sustaining a 2 cm head laceration and hematoma.</p> <p>3. Medical record review for Resident #2 documented an admission date of 10/14/09 with a readmission date of 4/25/11 with diagnoses of End Stage Renal Disease, Peripheral Vascular Disease, Neurogenic Bladder, Diabetes and Bilateral Below the Knee Amputation. Review of the facility's "Incident/Accident Report" documented Resident #2 had falls on 6/7/10, 10/2/10, 11/5/10 and 11/23/10. Review of the physician's orders dated 5/4/11 documented, "...BED BOLSTERS WHILE IN BED... FLOOR MATS AT BEDSIDE WHILE IN BED... BED ALARM WHILE IN BED... CHAIR ALARM WHILE IN W/C [wheelchair]..."</p> <p>Observations in Resident #2's room on 5/9/11 at 10:23 AM, 12:09 PM and 3:40 PM, on 5/10/11 at 11:30 AM and 3:30 PM and on 5/11/11 at 9:20 AM and 5:10 PM, revealed no bed bolsters, floor mats, bed alarm, or chair alarm in place.</p> <p>During an interview in the conference room on 5/11/11 at 1:15 PM, the Director of Nursing (DON) was asked how the facility ensured the fall interventions were in place. The DON stated, "I can't answer that... it's a nursing function to implement the interventions..."</p> <p>4. Medical record review for Resident #7</p> | F 323 | <ul style="list-style-type: none"> • Resident #15 – care plan was updated on 5/24/11 to reflect the current interventions in place for fall prevention/safety devices. • Resident #17 – bed bolsters were reapplied to resident on 5/11/11 at 12:15 pm. Safety devices are checked for appropriate placement at least each shift and resident #17 continues to have appropriate safety devices in place. • Resident #29 – No harm whatsoever was noted to this resident. Resident was immediately placed on one-on-one observation until a more secure environment could be established. <p>2. Residents with a safety/assistive device(s) ordered have the potential to be affected by this alleged deficient practice. Training, systematic changes, audits, and a performance improvement program as described below have been implemented to ensure all other residents with safety/assistive devices are consistently being checked for appropriate and safe placement and usage of these devices.</p> <p>3. The DON, ADON or designee trained all licensed nursing staff that all devices ordered for residents must be checked each shift for proper placement on</p> | |

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| F 323 | <p>Continued From page 3</p> <p>documented an admission date of 5/14/10, with a readmission date of 3/31/11 with diagnoses of Hypertension, Hypothyroidism, Urinary Tract Infection, Cerebral Vascular Accident, Dysphagia, Alzheimer's Disease, Foot Ulcer, Chronic Osteomyelitis, Peripheral Vascular Disease and Gastrostomy Tube. Nurses notes documented that the resident had a fall on 1/20/11. The care plan updated 1/20/11 documented the intervention for the "Resident to be reclined when up in geri-chair."</p> <p>Observations in Resident #7's room on 5/10/11 at 3:45 PM, revealed Resident #7 seated upright in a geri-chair.</p> <p>During an interview at the C wing nurses' station on 5/10/11 at 3:46 PM, Nurse #10 was asked what position Resident # 7's geri-chair should be in. Nurse #10 stated, "I'm not sure." When asked how care plan updates were communicated to other care providers, Nurse #7 stated, "...we tell them..."</p> <p>5. Medical record review for Resident #9 documented an admission date of 2/4/05 and a readmission date of 1/27/11 with diagnoses of Gastrostomy, Failure to Thrive, Dysphagia, Alzheimer's and Hypertension. Review of the Minimum Data Set dated 1/27/11 documented a cognitive summary score reflecting severe impairment. The care plan dated 2/3/11 documented "...half siderails while in bed... 2 person assist when caring for resident..." Review of the fall investigation dated 2/8/11 documented Resident #9's bedrail had been left down on the side of the bed and Resident #9 fell. Review of the fall investigation dated 4/12/11 documented</p> | F 323 | <p>resident and proper functioning and that this check must be documented on each resident's MAR. Licensed nursing staff were also trained that if they find any device to not be working properly they are to replace it with one that is functioning properly and to complete a work order on the device that is not functioning properly. All staff were educated on wandering residents, elopement, safety interventions for such, responding to door alarms, and code green on. The all staff training will be completed by 6/8/11.</p> <p>4. DON, ADON, or designee will audit 10 residents charts and check safety/assistive device placement for the corresponding 10 residents per week for the next 12 weeks to ensure care plan compliance is maintained and to ensure the safety devices are in place and functioning. DON/ADON or designee will report findings to the QA committee for the next 3 months for further recommendations and follow-up.</p> | |

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| F 323 | <p>Continued From page 4</p> <p>Certified Nursing Assistant (CNA) #9 transferred Resident #9 from chair to bed alone, her feet twisted up in the fall mat beside the bed and CNA #9 and Resident #9 fell to the floor. The staff failed to follow the care plan interventions which resulted in two avoidable falls for Resident #9.</p> <p>During an interview in the Resident #9's room on 5/10/11 at 3:55 PM, Nurse #9 stated the CNAs have access to the care plans and know that if a lift is not available to get two people to transfer a resident.</p> <p>During an interview in Resident #9's room on 5/11/11 at 9:30 AM, CNA #9 stated, "if no lift's available, get two people to transfer her [Resident #9]. Always two people."</p> <p>6. Medical record review for Resident #12 documented an admission date of 2/8/08 with diagnoses of Diabetes, Syphilis, Hypertension, History of Stroke and Glaucoma. Review of the care plan dated 2/25/11 documented bed bolsters as an intervention for falls.</p> <p>Observations in Resident #12's room on 5/9/11 at 3:00 PM and on 5/10/11 at 4:05 PM, revealed Resident #12 in bed with no bed bolsters present.</p> <p>During an interview in Resident #12's room on 5/10/11 at 4:05 PM, the Unit Manager confirmed there were no bed bolsters in place.</p> <p>7. Medical record review for Resident #15 documented an admission date of 12/18/07 and a readmission date of 6/11/10 with diagnoses of Diabetes, Anemia, Osteoporosis, Hypertension, Epilepsy and Dementia. Review of the care plan</p> | F 323 | | |
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| F 323 | <p>Continued From page 5</p> <p>dated 8/17/10 to present documented a fall on 5/9/10, 6/10/10, 6/14/10, 6/17/10, 7/16/10, 7/28/10, 7/29/10, 8/5/10, 10/7/10 and 11/15/10. There were no new interventions added to the care after the fall on 10/7/10. The care plan documented "...12/23/09-Chair alarm to alert staff of resident attempts at unassisted transfer... 7/29/10-May apply self releasing seat belt. D/C [discontinue] chair alarm."</p> <p>During an interview in the B wing dining room on 5/11/11 at 3:15 PM, Nurse #14 was asked if there were any new interventions on the care plan after each fall. Nurse #14 stated, "...I don't see them here... I'll have to look at the I [Incident] and A [Accident] reports..."</p> <p>During an interview in the conference room on 5/11/11 at 5:25 PM, Nurse #14 was asked if all nurses have the I and A report readily available when providing care. Nurse #14 stated, "No." When asked if the intervention written on the I and A report should be transferred to the care plan, Nurse #14 stated, "Yes."</p> <p>8. Medical record review for Resident #17 documented an admission date of 9/1/04 with a readmission date of 4/8/11 with diagnoses of Prostate Cancer, Dementia, Neurogenic Bladder and Acute Kidney Failure. Review of the care plan dated 4/19/11 documented, "...Bolsters to bed..."</p> <p>Observations in Resident #17's room on 5/9/11 at 10:10 AM, 12:09 PM, 4:45 PM and 5:50 PM, on 5/10/11 at 7:54 AM and 11:28 AM and on 5/11/11 at 8:30 AM and 11:24 AM, revealed no bed bolsters in place.</p> | F 323 | | |
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| F 323 | <p>Continued From page 6</p> <p>During an interview at the E wing nurses' station on 5/11/11 at 11:18, Nurse #6 confirmed that there were no bed bolsters in place for Resident #17.</p> <p>9. Medical record review for Resident #29 documented an admission date of 1/14/11 with diagnoses of Hypertension, Alzheimer's Disease, Dementia and Muscle Weakness. Review of the "Elopement Risk Assessment" dated 1/14/11 documented Resident #29 had the ability to move about the facility independently and had a history of wandering. Review of the nurses notes dated 1/14/11 at 6:00 PM, documented Resident #29 "makes statement about wanting to go home Wander guard on L [left] ankle."</p> <p>Review of the facility's elopement investigation dated 4/17/11 for Resident #29 documented on 4/17/11 at 8:46 AM "the resident entered the code to open the door and went down E Wing staircase... at 8:47 AM the resident exited D Wing back door... at 10:27 AM the staff on E wing noticed the resident missing and called a Code Green (discovery of missing resident) ...at 11:15 AM the resident was found at a fire station ... 11:35 AM resident returned to the facility via police car."</p> <p>Review of the facility's "Elopement Prevention and Management Program" documented "...Hourly checks (enough staff to monitor resident, properly respond to alarms or alert that indicated door has been opened."</p> <p>During an interview in the Administrator's office on 5/11/11 at 5:00 PM, the Administrator stated</p> | F 323 | | |

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| F 323 | <p>Continued From page 7</p> <p>when the staff heard the alarm sounding from the D wing back door, they performed a room to room check and they thought the resident had gone to the church activities because she had told them that was where she was going.</p> <p>The facility failed to properly respond by checking the resident when an alarm sounded indicating a door had been opened.</p> | F 323 | | |
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