

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN6007	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/17/2013
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RECEIVED
APR 26 2013

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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(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) COMPLETE DATE
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N 669	<p>1200-8-6-.06(4)(c)4. Basic Services</p> <p>(4) Nursing Services.</p> <p>(c) The Director of Nursing shall have the following responsibilities:</p> <p>4. Notify the resident ' s physician when medically indicated.</p> <p>This Rule is not met as evidenced by: Intakes: TN00031454</p> <p>Type C Pending Penalty #4</p> <p>Tennessee Code Annotated 68-11-804(c)4: Nursing homes shall notify the patient ' s physician of the condition of a patient, when it is medically indicated.</p> <p>Based on medical record review and interview, it was determined the facility failed to notify the resident's physician at the onset of a blister for 1 of 3 (Resident #1) sampled residents reviewed with with decubitus ulcers.</p> <p>The findings included:</p> <p>Medical record review for Resident #1 documented an admission date of 9/4/12 with diagnoses of Alzheimer's Disease, Diabetes Mellitus, Chronic Kidney Disease, Hypertension and Anorexia. Nurses notes dated 3/17/13 documented, "4 PM Noted blister on L [left] heel. O [no] c/o [complaints of] pain. Left open to air. Tx [Treatment] nurse notified. Will continue to observe." There was no documentation the physician was notified at the onset of the blister. Review of a Weekly Pressure Ulcer Report dated</p>	N669	<p>The statements made on this plan of correction 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> <ol style="list-style-type: none"> 1- The Responsible Party of Resident #1 has been notified of the pressure ulcer on 4/24/13 by the Unit Manager of this Unit. 2- All residents have the potential to be affected by this alleged deficient practice. 3- Director of Nursing or Assistant Director of Nursing to in-service all licensed nursing staff on Notification of Change of Condition to the Responsible Party. <p>The Director of Nursing or Assistant Director of Nursing to review incident reports with IDT team in the daily clinical meeting to ensure appropriate notification to the Responsible Party occurred.</p>	4/27/13
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Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
CEO, LNHA

(X6) DATE
4-25-13

Division of Health Care Facilities

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N 669	<p>Continued From page 1</p> <p>3/20/13 documented, "...STAGE II Size in CM [centimeters] 7.3 x [by] 7... Resident has large Fluid Filled Blister to L Medial Heel. Tx started..."</p> <p>During an interview in the Memory Care Nurses Station on 4/17/13 at 9:30 AM, Nurse #3 stated, "...There was no order [physician's order for treatment of the blister] on the 17th [3/17/13]..."</p> <p>During an interview in the Memory Care Nurses Station on 3/17/13 at 10:00 AM, Nurse #1 stated, "...On the 17th [3/17/13] we should have notified..."</p>	N 669		

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