MAR 14 2011

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

PRINTED: 02/28/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445125		C 02/25/2011

NAME OF PROVIDER OR SUPPLIER: AMERICARE HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 3391 OLD GETWELL RD, MEMPHIS, TN 38118

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F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	F 157	NOTIFY OF CHANGES	

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
TN00025061 and TN00026521

Based on medical record review and interview, it

AmeriCARE understands the important issues associated with proper notification to the resident's physician and responsible party. The following will be implemented immediately to prevent this deficiency in the future.
To identify other residents having the potential to be affected by this deficiency, the records of all residents with wounds will be audited to assure the physician has been notified of any significant change in the residents wound.
The Treatment Nurse will be in-serviced on notifying the physician of any significant change in the status of a resident's wound and on documenting this notification in the resident's medical record.
The Treatment Nurse will complete a Notification of Change in Resident Status Form and submit it to the DON daily.
The DON or Designee will then check the resident's medical record to assure the process has been completed.

accepted POC 3/11/11 DP PH

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dee Linnenkamp | TITLE: Administrator | (X6) DATE: 3-11-2011

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

This POC was revised 3/11/11 DP

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F 157	Continued From page 1 was determined the facility failed to ensure the physician was notified of a significant change in a pressure sore/wound for 2 of 10 (Residents #5 and 10) sampled residents. The findings included: 1. Medical record review for Resident #5 documented an admission date of 12/29/05 with diagnoses of Multiple Sclerosis, Depression, Bronchitis, Unspecified Schizophrenia and Esophageal Reflux. Review of the form titled "NON-PRESSURE SKIN CONDITION REPORT" for Resident #5 documented the following: a. 6/3/09 "1.4 by (x) 1.3 x < [less than] .01" with no staging. b. 6/10/09 "...[Shin wound] has a appearance of Stage III..." c. 6/17/09 "...[shin wound] a appearance of Stage III..." d. 6/23/09 "...[shin wound] a appearance of Stage III..." e. 6/30/09 "...[shin wound] a appearance of Stage III..." f. 7/8/09 "...[shin wound] a appearance of Stage III..." There was no documentation that the nurse had called the physician to notify that the wound had an appearance of Stage III. 2. Closed medical record review for Resident #10 documented an admission date of 12/19/09 and a readmission date of 6/15/10 with diagnoses of Acute Cerebrovascular Disease, Hemiplegia, Rheumatoid Arthritis, Paranoid Schizophrenia and Hypertension. Resident #10 also had diagnoses of Stage II Pressure Ulcers to the right and left buttocks and left posterior thigh on readmission from the hospital on 6/15/10. On	F 157	The Treatment Nurse will also submit to the DON a Monthly Wound Care Notification Form indicating that the physician has been notified of any significant change in the resident's wound. The DON or designee will then check to see if it is documented in the resident's record that the physician was notified. The effectiveness of this corrective action plan will be evaluated in the Quality Assurance Committee Meeting quarterly.	March 18, 2011

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F 157	Contin_ed From page 2 6/25/10 the sacrum pressure ulcer was staged as a Stage III. Review of the form entitled "WEEKLY PRESSURE ULCER HEALING RECORD" for Resident #10 indicated that the wound deteriorated on 7/20/10, 7/30/10 and again on 9/17/10. There is no indication that the physician was notified of the change in the wound and there were no physician's order for a change of treatment on 7/20/10, 7/30/10 and 9/17/10. The wounds did improve with the same treatments yet the physician was not notified of the changes. During an interview in the surveyor ready room on 2/23/11 at 12:00 PM, the director of Nursing (DON) was asked what she would expect to happen with a wound that documented as changing to a stage III. The DON stated, "...Call the physician, call the family, and possibly expect a change in the treatment [for the wound]..." During an interview in the surveyor ready room on 2/23/11 at 1:00 PM, the DON stated she could find no documentation to indicate that the physician was notified of the decline for Resident #10.	F 157		
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	F 280	F 280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE CARE PLANS Accurate and timely care planning fundamentals are critical to defining appropriate and necessary care of each and every AmeriCARE resident. This care plan deficiency will be addressed immediately in order to insure that other residents are not affected by un-timely care planning. The care plans of all residents with wounds will be reviewed to assure the care plan reflects the current status of the resident's wound.	

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F 280	Continued From page 3 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: TN00025061 Based on medical record review and interview, it was determined the facility failed to revise the comprehensive care plan to reflect the current status for wounds for 1 of 10 (Resident #5) sampled residents. the findings included: Medical record review for Resident #5 documented an admission date of 12/29/05 with diagnoses of Multiple Sclerosis, Depression, Bronchitis, Unspecified Schizophrenia, and Esophageal Reflux. Review of a physician's order dated 3/3/10 documented, "...CLEAN LT [left] SHIN W [with]/NS [normal saline], PAT DRY & [and] APPLY SANTYL & COVER W/ 4X[by] 4S & DRY DRESSING EVERY OTHER DAY..." Resident #5's care plan dated 9/29/09 and updated 3/16/10 did not document that Resident #5 had a wound nor were there intervention for the care of the wound. During an interview in the surveyor ready room on 2/23/11 at 11:07 AM, the Director of Nursing	F 280	To assure the care plans are revised timely to reflect the resident's present status, the RN Care Plan Coordinator will audit each resident's care plan after care plan conference utilizing the Care Plan Update Form to make sure all issues identified are addressed, revisions are made and continuation of current issues are addressed. This form will be submitted to the DON weekly who will randomly check care plans for revisions. In addition, the Treatment Nurse will submit to the DON a Monthly Wound Care Notification Form indicating that the care plans of resident's with wounds have been revised and/or continued. The DON or designee will randomly check to see if the care plan is current with the necessary revisions being made. All new or revised wound care plans will be generated in the computer by the Care Plan Coordinators and be placed in the resident's care plan. The effectiveness of this corrective action plan will be evaluated by the Quality Assurance Committee quarterly.	March 18, 2011

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F 280	Continued From page 4 stated, "...on the nursing care plan dated 9/29/09 to 3/16/10, the wound was not care planned."	F 280		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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. 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. This REQUIREMENT is not met as evidenced by: TN00025061 Based on medical record review and interviews, it was determined the facility failed to maintain a clinical record that was complete for 1 of 10 (Resident #5) sampled residents. The findings included: Medical record review for Resident #5 documented an admission date of 12/29/05 with diagnoses of Multiple Sclerosis, Depression, Bronchitis, Unspecified Schizophrenia and Esophageal Reflux. Review of the form titled "NON-PRESSURE SKIN CONDITION REPORT" for Resident #5 documented the following: a. 6/3/09 "1.4 by (x) 1.3 x < [less than] .01" with	F 514	RECORDS ACCURATE/ ACCESSIBLE AmeriCARE understands the importance of maintaining records and documents. Due to a large leak in the circulation pump of our boiler room which is not visited regularly, many records were destroyed. Facility Business , Administration related records and DON investigation reports that were stored in that area, were totally exposed and the legibility of most documents were damaged beyond recovery. Residents Medical Records were in a separate area and were not affected. To ensure this problem does not re-occur, all investigation reports will be stored in the Medical Record Room. All documents will be stored at least 12 inches above the floor and documents will also be protected with a plastic cover.	March 8, 2011

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F 514	Continued From page 5 no staging. b. 6/10/09 "...[Shin wound] has a appearance of Stage III..." c. 6/17/09 "...[shin wound] a appearance of Stage III..." d. 6/23/09 "...[shin wound] a appearance of Stage III..." e. 6/30/09 "...[shin wound] a appearance of Stage III..." f. 7/8/09 "...[shin wound] a appearance of Stage III..." There was no documentation that the nurse had called the physician to notify that the wound had an appearance of Stage III. Review of the nurses notes documented the following: a. 2/13/10 Resident #5 had reported that her wig had been knocked off by another resident. b. 2/15/10 "...8P [PM] Found another resident in her rm [room] this resident had threatened her & tried to hit her. Both [residents] were cursing & [and] calling each other names..." c. 3/18/10 documented, "Resident [#5] noted c [with] large lump to rt [right] side of face and cheek area..." During an interview in the surveyor ready room on 1/19/11 at 2:00 PM, the Director of Nursing (DON) was asked for any incident reports concerning falls and any resident to resident altercations for Resident #5. The DON stated, "...in my notes I have that she [Resident #5] fell on the 1?th [March 2010] and was sent to the hospital on the 19th [March 2010]but I can't find anything else on her. The files were flooded in the basement... [We] have nothing on a resident to resident altercation... " The DON stated that she could not get those incident reports as the facility	F 514		

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F 514	Continued From page 6 had flooding in the basement where they kept the records. During an interview in the surveyor ready room on 2/23/11 at 12:15 PM, the DON stated that the treatment nurse usually wrote her own notes on the wounds and they might include notification to the physician. The DON stated she would ask medical records to see if they could find them. The DON returned to the room at 12:30 PM and stated, "There are no more notes on that [wounds]. Those records were probably in the flooded area..."	F 514		