

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

PRINTED: 03/29/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/20/2012
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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 000	<p>INITIAL COMMENTS</p> <p>On March 20, 2012 an investigation of complaint #'s TN00028953, TN00029176, TN00029409 and TN00029422 was completed. The deficiencies were cited as followed for the complaints investigated: TN00028953 - F314 and F465; TN00029176 - F325; TN00029409 - F309 and F314 and TN00029422 - F465.</p> <p>F 309 SS=D 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, 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: Complaint #TN000029409</p> <p>Based on medical record review and interview, it was determined the facility failed to follow physician's orders for catheter care for 2 of 6 (Residents #3 and 6) sampled residents.</p> <p>The findings included:</p> <p>1. Medical record review for Resident #3 documented an admission date of 8/17/01 with diagnoses of Chronic Stage III and IV Pressure Ulcers, History of Unspecified Osteomyelitis, Adult Failure to Thrive, Anemia, T12 Paraplegia due to Motor Vehicle Accident and Hyperlipidemia. Review of the March 2012</p>	F 000	<p>F 309 F309</p> <p>The facility strives to ensure that each resident receives, and the facility provides, the necessary care and services to attain and maintain the highest practicable, physical, mental, and psychosocial well-being of the residents.</p> <p>Of the two (2) residents affected by this deficient practice, one resident was hospitalized when the deficient practice was identified and has not returned to the facility.</p> <p>The other resident affected by this deficient practice has been instructed on self performance of catheter care. The staff will continue to document the care.</p>	
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RECEIVED

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Robert L. Montham</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4-12-12</i>
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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 309	Continued From page 1 current physician's orders documented "Foley Catheter to promote healing of decubiti" and "Foley Cath [catheter] care w [with] / [and] soap & [and] H2O [water] every shift." During an interview in Resident #3's room on 3/20/12 at 10:00 AM, Resident #3 was asked how often staff cleaned the Foley catheter. Resident #3 stated, "They never do except when they change it." Resident #3 stated, "I clean it when I take a shower." Review of the nursing care activity of daily living (ADL) records revealed blank spaces for care of the Foley catheter. The October 2011 had 42 blanks, November 2011 had 60 blanks, December 2011 had 40 blanks, January 2012 had 35 blanks, February 2012 had 45 blanks and March 2012 had 27 blanks that did not document catheter care as being done. 2. Medical record review for Resident #6 documented an admission date of 1/16/00 with diagnoses of Diabetes Mellitus, Anoxic Brain Damage and Hypertension. Review of the March 2012 physician's orders documented, "Foley Cath care w/H2O every shift." Review of the ADL records revealed there was no documentation that catheter care was provided on the 11/7 shift for 3/1/12 and 3/2/12. The facility failed to document catheter care as ordered for Resident #3 and Resident #6.	F 309	To ensure that other residents with catheters are not affected by this deficient practice, the Nursing Supervisor will check weekly for one (1) month, then monthly thereafter, to assure that catheter care is performed and documented per physician's orders. The DON will randomly check to see that the care is documented. The findings from the above will be discussed in the Quality Care (QC) meeting and in the quarterly Quality Assurance (QA) Meeting. The policy for catheter care will be revised. All nursing staff will be in-serviced on this revision. Completion Date: April 2 , 2012		
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314	F 314 The facility strives to ensure that a resident who enters the facility without pressure		

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F 314	<p>Continued From page 2</p> <p>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: Complaints #TN00028953 and TN00029409</p> <p>Based on policy review, medical record review, observation and interview, it was determined the facility failed to complete weekly assessments of skin for 4 of 6 (Residents #1, 2, 3 and 6) sampled residents with a pressure ulcer.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Review of the facility's "...Identifying Residents at Risk for Pressure Ulcers" policy documented, "...1. RISK ASSESSMENT... c. Re-assess all patients weekly..." Review of the facility's "WOUND CARE CHARTING" policy documented, "...A. Weekly measurements should be done on Wednesday of each week unless treatment nurse indicates otherwise..." Medical record review for Resident #1 admission date of 7/20/09 with diagnoses of Gastroesophageal Reflux Disease, Senile Dementia, Hypertension, Vitamin D Deficiency, Heart Failure and Pacemaker. The resident had a history of Pressure Ulcers to Buttocks. Review of 	F 314	<p>ulcers does not develop pressure ulcers, unless the individual's clinical condition demonstrates that they were unavoidable: and a resident having pressure ulcers requires necessary treatment and services to promote healing, prevent infection and prevent new ulcers from developing.</p> <p>Three (3) of the four (4) residents affected by this deficient practice had a full body assessment completed. One (1) of the residents was hospitalized when the deficient practice was identified and has not returned to the facility.</p> <p>All new residents will have a skin assessment completed by the admitting nurse and the treatment nurse. Those identified with existing skin impairments and those found to be at risk for skin breakdown will have appropriate interventions initiated.</p> <p>All existing residents will have a skin evaluation completed. Thereafter, skilled residents will have a skin assessment completed bi-monthly. ICF residents will have a skin assessment completed monthly.</p>		

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F 314	<p>Continued From page 3</p> <p>the skin assessment form dated 11/14/11 documented, "0 [no] new skin breakdown noted @ [at] this time..."</p> <p>Observation in Resident #1's room on 3/20/12 at 2:10 PM, revealed Resident #1 had healed areas to the right buttock with no skin breakdown at present.</p> <p>During an interview in the conference room on 3/19/12 at 1:30 PM, the Director of Nursing (DON) stated that there are no further skin assessments found on this resident.</p> <p>3. Medical record review for Resident #2 documented an admission date of 9/20/06 with diagnoses of Schizophrenia, Hypertension, Diabetes Mellitus and Osteoarthritis. Review of the weekly skin assessment dated 9/29/11 documented, "...no breakdown noted." Review of the next weekly skin assessment dated 10/12/11 documented, "...open area to Lt [left] lateral foot Tx [treatment] initiated..." and the weekly skin assessment dated 10/19/11 was blank. Review of Resident #2's care plan dated 6/16/11 and updated 2/23/12 documented, "...POTENTIAL FOR PRESSURE ULCERS... 2 Assess resident skin condition weekly..."</p> <p>Observation in Resident #2's room on 3/20/12 at 11:00 AM, revealed Resident #2 had a Stage II pressure ulcer on the left lateral foot.</p> <p>During an interview in the conference room on 3/19/12 at 1:35 PM, the DON was asked how often do the nurses perform skin assessments. The DON stated, "...suppose to do their skin assessments weekly..."</p>	F 314	<p>The Unit Nurse will complete a Skin Assessment daily, according to the Skin Assessment Schedule. The Unit Nurse will also include, in the daily or weekly charting, a skin assessment in the Nurse's Notes.</p> <p>The Nursing Supervisor will check, initial, and date weekly that the skin assessments scheduled for that week, have been completed, as indicated in the monthly schedule.</p> <p>The Bath Team will assist with proper assessment of the skin when giving baths, and reporting skin problems to the Charge Nurse and documenting the findings on the Skin Alert Sheet.</p> <p>The timeliness of the completion of the skin assessments will be reviewed during a Quality Care (QC) meeting, and discussed quarterly at a Quality Assurance (QA) Meeting.</p> <p>The facilities policy for identifying residents at risk for pressure ulcers and the Wound Assessment and Documentation Policy have been revised.</p>	
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F 314	<p>Continued From page 4</p> <p>4. Medical record review for Resident #3 documented an admission date of 8/17/01 with diagnoses of T12 Paraplegia, Chronic Stage III and IV Pressure Ulcers, Hyperlipidemia, Adult Failure to Thrive, Anemia and History of Unspecified Osteomyelitis. Review of the weekly pressure ulcer healing record dated 10/10/11 documented a Stage IV pressure ulcer to the "left ishal" with a measurements of 3 centimeters (cm) by (x) 3 cm x 5 cm. The next entry dated 10/20/11 documented the same measurements as before. An entry on 12/13/11 documented measurements of 3 cm x 3 cm x 4 cm. There is no further documentation of assessment of this pressure ulcer until 12/29/11 still having the same measurements. An entry on 1/5/12 documented measurements of 3 cm x 3 cm x 4 cm. There is no further documentation until 1/18/12 which documented a measurement of 3 cm x 3 cm x less than (<) 0.1 cm. Review of the weekly skin assessments for Resident #3 revealed blank assessment forms dated 11/1/11, 2/14/11, 2/21/11 and 3/6/11.</p> <p>5. Medical record review for Resident #6 documented an admission date of 1/16/00 with diagnoses of Diabetes Mellitus, Hypertension, Cerebrovascular Accident and Anoxic Brain Damage. Review of the weekly pressure ulcer healing record dated 12/12/11 documented a Stage II pressure ulcer to the left elbow with measurements of 1 1/2 cm x 1 cm X <0.1 cm. The next entry documented on the weekly pressure ulcer healing record was dated 1/5/12 for the Stage II pressure ulcer with measurements of 1 1/2 cm x 1 cm x < 0.1 cm. The next entry was dated 1/12/12 for the Stage II</p>	F 314	<p>All nursing staff will be in-serviced on the revised policies.</p> <p>Completion Date: April 21 2012</p>	

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F 314	<p>Continued From page 5</p> <p>pressure ulcer with measurements of 1 cm x 1 cm x <0.1 cm. The facility was unable to provide any documentation of the wound assessments of the left elbow after the entry on 1/12/12. Review of the weekly pressure ulcer healing record dated 1/23/12 documented a Stage II pressure ulcer to the bottom of the left heel with measurements of 1 1/2 cm x 1 cm x <0.1 cm. The next entry was dated 2/6/12. Review of the weekly pressure ulcer healing record dated 1/18/12 documented a Stage II pressure ulcer on the sacral with measurements of 2 cm x 2 1/2 cm x <1.0 cm. The next entry was dated 2/6/12 for the Stage II pressure ulcer with measurements of 2 cm x 2 1/2 cm <1.0 cm. The next entry was dated 2/22/12 for the Stage II pressure ulcer with measurements of 2 cm x 2 cm x <1.0 cm. Review of the March 2012 physician's order documented the resident was still receiving a treatment of, "Clean Lt [left] elbow w NS [normal saline] Pat dry + [and] apply Santyl + 4X4 drsg [dressing] qd [daily]."</p>	F 314		
F 325 SS=E	<p>6. The facility failed to complete weekly skin assessments for Residents #1, 2, 3 and 6.</p> <p>483.25(j) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p>	F 325	<p>F 325</p> <p>The facility strives to ensure that each resident's nutritional status is maintained unless unavoidable and receives a therapeutic diet when there is a nutritional problem.</p> <p>All residents affected by this deficient practice were evaluated by the RD.</p>	

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F 325	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #TN00029176</p> <p>Based on policy review, medical record review and staff interview, it was determined the facility failed to assess for nutritional problems to ensure maintenance of acceptable parameters of nutritional status for 4 of 6 (Residents #1, 2, 4 and 5) sampled residents.</p> <p>The findings included:</p> <p>1. Review of the facility's "...WEIGHT MANAGEMENT..." policy documented, "...To initiate appropriate interventions when there is an alteration in nutritional status... Parameters for evaluating significant unintended weight loss are... INTERVAL... 1 month... SIGNIFICANT LOSS... >[greater than] or above 5% [percent]... INTERVAL... 6 months... SIGNIFICANT LOSS... >10%..."</p> <p>2. Medical record review for Resident #1 documented an admission date of 7/20/09 with diagnoses of Senile Dementia, Hypertension, Gastroesophageal Reflux Disease, Vitamin D Deficiency, Heart Failure and Pacemaker. Review of the March 2012 physician's orders documented the resident was to receive a tube feeding of Jevity 1.2 cal at 75 cubic centimeters per hour (cc/hr) for 16 hours. There was no documented dietary assessments for a resident receiving a tube feeding after 10/19/11.</p>	F 325	<p>A nutritional assessment will be completed on all existing residents, by the RD, to identify other residents who may be affected by the deficient practice.</p> <p>All new admissions and re-admissions will have a nutritional assessment completed within seven (7) days of admission. Any significant change in a resident's status will require an immediate nutritional assessment. All residents will receive a quarterly nutritional assessment thereafter, according to the Care Plan Schedule. Any problems identified will be addressed with the appropriate interventions.</p> <p>The status of the dietary assessments will be reported during a Quality Care (QC) Meeting and discussed quarterly in the Quality Assurance (QA) Meeting.</p> <p>Completion Date: April 2, 2012</p>	
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F 325	<p>Continued From page 7</p> <p>During an interview in the conference room on 3/19/12 at 1:30 PM, the Director of Nursing (DON) stated that no dietary assessments had been completed on the resident since that date due to the absence of a Registered Dietician in the facility.</p> <p>3. Medical record review for Resident #2 documented an admission date of 9/20/06 with diagnoses of Schizophrenia, Hypertension, Diabetes Mellitus and Osteoarthritis. Review of Resident #2's weight tracking for 2011 documented a weight of 180 pounds (#s) on 12/27/11 and a weight of 168 #s on 3/5/12 which resulted in a 7% weight loss in 3 months. Review of the nutritional progress notes dated 10/26/11 documented, "CBW [current body weight] 195 [pounds] Significant weight loss x 3 and 6 months..." There was no documentation of a dietary assessment after 10/26/11. Review of the care plan dated 12/1/11 documented, "...weight loss resolved..."</p> <p>4. Medical record review for Resident #3 documented as admission date of 8/17/01 with diagnoses of T12 Paraplegia, Chronic Stage III and IV Pressure Ulcers, Adult Failure to Thrive, Anemia, Hyperlipidemia and a History of Unspecified Osteomyelitis. Review of the nutritional progress notes dated 10/5/11 documented, "...No September wt [weight] August wt of 136 # is below DBW [desired body weight] however within resident's usual wt... Resident has Stage 4 ischeal + [and] Stage 3 r [right] buttocks wounds being tx [treated]..." There was no documentation of a dietary assessment after 10/5/11. The weight tracking for 2012 documented a weight of 128 on 3/13/12. The care</p>	F 325		
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F 325	<p>Continued From page 8 area assessments (CAA) review report dated 12/23/11 documented, "wounds with little improvement. Noncompliant with supplement."</p> <p>During an interview in Resident #3's room on 3/20/12 at 10:00 AM, Resident #3 stated that he had had a recent weight loss. Resident #3 stated, "I have a good appetite now. I told them that I will gain it back."</p> <p>5. Medical record review for Resident #4 documented an admission date of 9/1/11 with diagnoses of Subdural Hematoma / Craniotomy and Schizophrenia. Review of the weight tracking record for 2011 documented a weight of 128 on 10/22/11 and a weight of 118 on 11/12/11 which resulted in a 7.8% weight loss in less than 1 month. Review of Resident #4's care plan dated 12/8/11 documented, "Problem... SIGNIFICANT WEIGHT LOSS. Start Date: 12/08/11..." Review of the medical record revealed no interventions were put in place before 12/8/11 to prevent further weight loss.</p> <p>During an interview in the conference room on 3/19/12 at 1:30 PM, the Director of Nursing (DON) was asked how weight loss was managed. The DON stated, "...[Name of staff member] and the Dietary Manager look over the weights, the weight team meets 2 times a month... they address weight loss weekly..."</p> <p>6. Medical record review for Resident #5 documented an admission date of 3/22/11 with diagnoses of Weakness, Malnutrition, Falls Urinary Tract Infection, Diabetes Mellitus, Hypertension and Failure To Thrive. Review of the weight tracking record for 2012 documented a</p>	F 325		
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F 325	Continued From page 9 weight of 131 on 10/11/11 and a weight of 121 on 1/19/12 which was a 7.5% weight loss in 3 months. Review of the nutritional progress note dated 10/26/11 documented, "...Significant weight loss x [times] 1, 3 + [and] 6 months. CBW [current body weight] 131 # [pounds]." The next entry on the nutritional progress note was dated 3/19/12. The facility was unable to provide documentation the facility attempted or considered alternative approaches for the significant weight loss on 1/19/12.	F 325			
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Complaints #TN00028953 and TN000029422 Based on observation, it was determined the facility failed to provide a sanitary environment for 1 or 6 (Resident #1) sampled residents. The finding included: Observation in Resident #1's room on 3/19/12 at 10:30 AM, revealed four dead roaches. One dead roach was observed beside bed one, one in the corner behind the bedside chest and two beside the larger chest. There was a soiled area under the head of the bed with a brown edge which appeared to have been spilled formula from the resident's tube feeding.	F 465	F 465 This facility will provide a safe, sanitary and comfortable environment for residents, families, and visitors. The room of the resident which was affected by the facilities deficient practices was thoroughly cleaned - <u>furnishings were removed and cleaned</u> - the floor was cleaned and mopped - the liquid residue under the head of the bed was removed, as were the dead roaches. The entire facility, with emphasis on resident's rooms and common areas will be professionally treated for pests, especially areas where food particles and/or liquid medication spills occur. The nurse administering the liquid medication is responsible for any spills or dripping that may occur, and should clean it up immediately.		

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

PRINTED: 03/29/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/20/2012
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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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(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 465

Continued From page 10

Observations in Resident #1's room on 3/20/12 at 10:15 AM, revealed the spill and four dead roaches were still present in room and the wedge cushion from the resident's bed was sitting on the floor near the dead roaches.

During an interview in Resident #1's room on 3/19/12 at 10:30 AM, a family member stated that the formula drips on the floor, and the bugs come to it.

F 465

All residents who consume food in their rooms are more likely to see pests because of food spills. When meal trays are collected, staff will check the floor for such spills and remove the food particles from the floor.

A monthly (or as needed) service contract with a pest control company has been initiated. As of this date, two (2) campus-wide treatments have been completed. Staff will be asked to note any visual sightings of pests, especially in resident's rooms and general common areas, and to report such to the Charge Nurse, who will report the sightings and location to the Building Support Manager, in a timely manner. Residents/staff will be asked to be aware of food items stored or consumed in resident's rooms and other common areas, where it may fall on the floor, etc. During late shifts, liquids and/or food on the floor should be spot cleaned by the nurse and/or CNA and a request for the early morning housekeeping staff to address the cleaning more thoroughly, utilizing the Daily Housekeeping Record.

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Resident's rooms will be cleaned daily: floor swept or dry mopped initially, all furniture wiped down, and bathroom cleaned. Special attention will be given to corners, behind furniture and doors. The final step of the cleaning process will be to wet mop the unit. The Housekeeping Staff will check-off items covered, by the cleaning, utilizing the Daily Housekeeping Record. The Record will also indicate the date and time the unit was cleaned, as well as problems noted during the process. Records will be signed by the housekeeper and filed daily with the Building Support Manager, who will randomly check units.

Completion Date: April 2 2012

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