

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

 PRINTED: 01/21/2011  
 FORM APPROVED  
 OMB NO. 0938-0391

45th 3/06/11

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  01/20/2011
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 176 SS=D	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to assess one resident (#14) of twenty-one residents reviewed prior to allowing self administering of a drug.</p> <p>The findings included:</p> <p>Resident #14 was admitted to the facility on October 9, 2009, with diagnoses including Pneumonia, Hypertension, Anemia, and Congestive Heart Failure.</p> <p>Medical record review of the monthly physician recapitulation orders' dated January 2011, revealed "...Albuterol (bronchodilator) use for Aerosol treatments twice daily..."</p> <p>Observation outside the resident's room on January 19, 2011, at 9:32 a.m., revealed charge nurse #1 obtained Albuterol for resident #14, entered the resident room, and started the Albuterol treatment. Continued observation revealed the charge nurse left the resident's room while the Albuterol was still being administered.</p> <p>Interview and medical record review with charge nurse #1 on January 19, 2011, at 9:35 a.m., at the 100 hall nurse's desk, confirmed the resident had not been assessed for self administration of</p>	F 176	<p>F - 176 Resident #14 has been reassessed by an interdisciplinary team to ascertain the ability to self-administer medications.</p> <p>All residents with aerosol treatments have been identified and assessed by an interdisciplinary team for the ability to self-administer medications.</p> <p>The policy for self-administration of medications has been reviewed. Licensed staff have been re-educated on the policy for screening for self-administering medications.</p> <p>Director of Nursing or designee will audit medical records to ascertain residents self-administering medications have been screened by an interdisciplinary team. Audits will be conducted on 5 residents per week for 4 weeks and 2 residents per week for 8 weeks.</p>	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
<i>William W Scott, MHA</i>		Administrator		01.29.2011

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 176 F 246 SS=D	<p>Continued From page 1 the albuterol.</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure a call light was in reach to accommodate the needs of one resident (#15) of twenty-one residents reviewed.</p> <p>The findings included:</p> <p>Resident #15 was admitted to the facility on March 17, 2008, with diagnoses including Debility, Difficulty Walking, Chronic Obstructive Pulmonary Disease, and Renal Insufficiency.</p> <p>Medical record review of the resident care plan dated June 7, 2010, revealed "...requires staff interventions or assistance to perform ADL's (activities of daily living) d/t (due to) poor eye sight..."</p> <p>Observation in the resident's room on January 19, 2011, at 3:18 p.m., revealed the resident seated in a wheelchair. Continued observation at this time revealed the resident call light (used to call for assistance) was on the night stand behind and</p>	F 176 F 246	<p>The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate.</p> <p>F - 246 Resident #15's call light has been placed within reach of resident.</p> <p>All residents call light's will be within reach when in their room to accommodate the needs of each resident.</p> <p>The call-light policy has been reviewed and the staff have been re-educated on the call-light policy.</p> <p>The Director of Nursing or designee will observe 10 rooms per week for 4 weeks and then 5 rooms per week for 8 weeks to determine appropriate call-light placement.</p>	02-25-2011

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F 246	Continued From page 2 out of reach of the resident.  Interview with the resident at this time revealed the resident wanted to lie down in bed but could not find the call light.  Continued interview and observation with Certified Nursing Aide (CNA #1) and CNA #2 in the resident's room on January 19, 2011, at 3:20 p.m., confirmed the resident had poor eye sight and the facility had failed to accommodate the resident's needs by not having the call light within easy reach.	F 246	The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate.	02-25-2011	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to follow physician's orders for sliding scale insulin for one resident (#3) and failed to follow physician's orders for restorative nursing for one resident (#7) of twenty-one residents reviewed.  The findings included:  Resident #3 was admitted to the facility on December 15, 2009, with diagnoses including Diabetes Mellitus Type II, Cardiomyopathy, Rhabdomyolysis, and Dementia.  Medical record review of the physician's recapitulation orders dated November 1 through 30, 2010, and December 1 through 31, 2010,	F 281	F -- 281 Resident # 3 has been examined by MD/ NP and new orders obtained in relation to Insulin dosing. No adverse effects were noted.  All residents with orders for sliding scale insulin have been identified. Orders have been reviewed and revised and sliding scale insulin administered as ordered.  The standing orders have been revised to reflect current sliding scale insulin protocol. The hypoglycemic protocol has been revised. The diabetic monitoring flowsheet has been revised to reflect current sliding scale insulin		

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F 281	<p>Continued From page 3</p> <p>revealed "...Sliding Scale Insulin per Standing Order Daily and at 5P (5:00 p.m.)...(See Diabetic Flow Sheet).."</p> <p>Medical record review of the Diabetic Flow Sheets dated November 1 through 30, 2010, and December 1 through 31, 2010, revealed "...Order for Sliding Scale...Novolin R...70-150: no insulin; 151-200: 4 units (units of insulin to be administered); 201-250: 6 units; 251-300: 8 units; 301-350: 10 units; 351-400: 12 units; &gt; (greater than) 400: 14 units..."</p> <p>Continued medical record review of the Diabetic Flow Sheets revealed on November 18, 2010, at 5:00 p.m., a fingerstick blood sugar of 202 with 4 units of insulin administered; on December 12, 2010, at 5:00 p.m., a fingerstick blood sugar of 207 with 4 units of insulin administered; and on December 22, 2010, at 5:00, a fingerstick blood sugar value of 203 with 4 units of insulin administered.</p> <p>Observation on January 18, 2011, at 3:00 p.m., revealed the resident in a wheelchair talking with a visitor in the hallway outside the resident's room.</p> <p>Interview with the Director of Nursing (DON) at the nursing station on January 18, 2011, at 3:35 p.m., confirmed the facility had failed to administer the correct amount of insulin as ordered by the physician.</p> <p>Resident #7 was admitted to the facility on January 9, 2010, with diagnoses including Fracture Femur, Aftercare Traumatic Fracture Hip, Hypertension, Atrial Fibrillation, Encephalopathy, and Atherosclerosis.</p>	F 281	<p>dosages. The licensed staff have been re-educated on the hypoglycemic protocol and administration of sliding scale insulin.</p> <p>The DON or designee will audit diabetic monitoring flow sheets of 5 resident per week for 4 weeks and then 3 residents per week for 8 weeks for administration of correct insulin dosages.</p> <p>The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate</p> <p>Resident #7 has been rescreened by physical therapy and placed in a restorative nursing program.</p> <p>All residents who have been discharged from therapy have been screened to ascertain if restorative nursing is appropriate.</p>	

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F 281	<p>Continued From page 4</p> <p>Medical record review of the Minimal Data Set (MDS) dated December 19, 2010, revealed the resident had long term memory impairment, moderately impaired cognitive skills for daily decision making, and required two-person assistance with transfers.</p> <p>Medical record review of a Physician's Telephone Order dated December 20, 2010, revealed "...Pt (patient) to cont. (continue) P.T. (physical therapy) 3 x /wk x 1 wk (three times a week for one week) then will turn over to restorative program..."</p> <p>Medical record review of the Physical Therapy Updated Plan of Progress dated December 20, 2010, revealed "...Discharge Recommendations/Prognosis...Restorative program...D/C (discharge) to Restorative..."</p> <p>Medical record review of Physical Therapy Daily and Weekly Progress Notes revealed the resident received P.T. treatments on December 20-22, 2010, (three treatments for one week) and was discontinued.</p> <p>Interview with the Restorative Certified Nursing Assistant (CNA) #1, on January 18, 2011, at 2:00 p.m., at the 100-hall nurse's station, revealed Restorative CNA #1 had not seen the physician's order dated December 20, 2010, and the resident was not started on a restorative program.</p> <p>Interview with the Physical Therapy Clinical Manager, on January 18, 2011, at 2:35 p.m., in the 100-hallway, revealed the resident's last P.T. treatment was December 22, 2010, and the resident was to begin the restorative program.</p>	F 281	<p>A process has been developed for therapy staff to notify nursing staff of any post therapy restorative recommendations.</p> <p>The Director of Nursing or designee will audit physician orders for residents discharged from therapy and remaining in facility weekly for 12 weeks to determine appropriate restorative follow-up.</p> <p>The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate.</p>	02-25-2011

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F 281	Continued From page 5	F 281		
F 514 SS=D	<p>Interview with the Director of Nursing (DON), on January 20, 2011, at 9:15 a.m., in the DON's office, confirmed the facility failed to follow the Physician's Telephone Order dated December 20, 2010, to place the resident on a restorative nursing program.</p> <p>483.75(l)(1) FIES 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 a complete and accurate medical record for one resident (#3) of twenty-one residents reviewed.</p> <p>The findings included:</p> <p>Resident #3 was admitted to the facility on December 14, 2009, with diagnoses including Diabetes Mellitus Type II, Cardiomyopathy, Rhabdomyolysis, and Dementia.</p>	F 514	<p>F -- 514 Resident #3 has been examined by MD/ NP and new orders obtained in relation to Insulin dosing. Medication administration record reflects new orders. Resident had no adverse effects.</p> <p>Residents receiving insulin have been identified. The Medical Records of all residents receiving insulin contain current insulin standing orders.</p> <p>Licensed staff have been re-educated on the placement of standing orders on medical records.</p> <p>The DON or designee will perform audits of medical records of residents receiving insulin to ascertain standing orders are present. 5 records per week will be audited for 4 weeks and 3</p>	

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F 514	<p>Continued From page 6</p> <p>Medical record review of the physician's recapitulation orders dated January 1 through 31, 2011, revealed "...Sliding Scale Insulin per Standing Order Daily and at 5P (5:00 p.m.)..."</p> <p>Medical record review revealed no current Standing Orders for Sliding Scale Insulin on the resident's medical record.</p> <p>Interview with the Director of Nursing (DON) on January 19, 2011, at 8:30 a.m., in the conference room confirmed insulin was being administered according to the current Standing Orders for Sliding Scale Insulin. Continued interview with the DON confirmed the current Standing Orders for Sliding Scale Insulin were not on the resident's medical record. Further interview with the DON confirmed the facility had failed to maintain a complete and accurate medical record for this resident.</p>	F 514	<p>records per week for 8 weeks will be audited to ascertain that standing orders are present.</p> <p>The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting monthly for three (3) months and recommendations made as appropriate</p>	02-25-2011	