<table>
<thead>
<tr>
<th>ID TAG</th>
<th>(x4) I D PREFIX</th>
<th>SUBREVIEW STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</th>
<th>(x5) COMPLETION DATE</th>
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</thead>
<tbody>
<tr>
<td>F 225</td>
<td>F 225</td>
<td><strong>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</strong></td>
<td></td>
<td><strong>F 225 - Resident # 2 remains a resident of Asbury Place, and has had no subsequent allegations of abuse.</strong></td>
<td>12/14/12</td>
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<td>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</td>
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<td>Subsequent abuse allegations have been reviewed, and thorough investigations have been completed by the Administrator.</td>
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<td>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</td>
<td></td>
<td>The Abuse Policy has been reviewed by the Administrator. The RN has re-educated all of the associates on the need to report abuse immediately. The Administrator has re-educated the management associates on the need to complete a thorough investigation.</td>
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<td>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</td>
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<td>All abuse allegation investigations will be audited to determine that investigations are thorough and complete for the next 3 months by the Administrator.</td>
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<td>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</td>
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This REQUIREMENT is not met as evidenced by:

Based on review of facility policy, medical record review, review of facility investigation, observation, and interview, the facility failed to thoroughly investigate an allegation of abuse for one resident (#2) of thirteen sampled residents.

The findings included:

Review of facility policy Number RS-N6G-041 most recently revised on April 3, 2005, revealed, "...Topic: Abuse/Neglect/Mistreatment...Alleged violations will be thoroughly investigated by the Director of Nursing (DON)...."

Medical record review revealed the resident (#2) was admitted to the facility on December 8, 2011, with diagnoses including Rhabdomyolysis and Psoriatic Arthritis.

Medical record review of a History and Physical dated November 30, 2011, revealed, "...closed head injury...alert and oriented answered questions appropriately..." Medical record review of a Minimum Data Set dated September 11, 2012, revealed the resident was impaired with decision-making skills and dependent on staff for hygiene.

Interview with the Director of Nursing (DON) on October 29, 2012, at 9:00 a.m., in the family room, revealed the facility had reported an allegation of verbal abuse regarding sampled Resident #2.

Review of facility investigation (statement by
**F 226** Continued From page 2  
Certified Nursing Assistant - CNA) # 1 dated October 24, 2012, revealed, "... on 10-21-12... (Alleged Perpetrator - AP)...telling (resident) that (resident) know better than to smear (faces)...was a grown adult...and when (AP) was getting (resident) out of bed (resident) became combative by kicking... (Resident) started yelling at (AP)...(AP) told (resident)...If kept that up (Resident) (expletive) would stay up until 11 p.m."  

Review of facility investigation (the AP's statement) dated October 24, 2012, revealed, "When I clock (clocked) in want to my floor. A housekeeper (#1) stop (stopped) me...said (resident) had (faces) all over...not cleaning (resident)'s) room until someone clean (cleaned) (resident) up...I clean (cleaned) (resident) up and try to get (resident) up..."  

Continued review of facility investigation revealed no statement from the referenced housekeeper...  

Observation on November 1, 2012, at 2:58 p.m., revealed the resident utilized the call light, requested toileting assistance, and the assistance was provided.  

Interview with the resident on November 1, 2012, at 3:25 p.m., revealed the resident was disoriented to time, had never been mistreated, and had no complaints. Continued interview revealed the resident would rely on family to address any complaint that may occur.  

Interview with the Housekeeper #1 on November 5, 2012, at 1:22 p.m., revealed she was in the
Continued From page 3

room while the AP provided care to the resident.

Interview with the DON on November 2, 2012, at 4:00 p.m., in the family room, revealed the facility's investigation did not include a statement from Housekeeper #1. Continued interview confirmed the facility failed to thoroughly investigate an allegation of abuse for Resident #2.

C/O: #30074

483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

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.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, review of facility investigation, observation, and interview, the facility failed to provide adequate supervision and/or safety device to prevent recurrent falls for one resident (#8) of thirteen sampled residents.

The findings included:

Resident #8 was admitted to the facility on November 9, 2001, with diagnoses including Vascular Dementia and Schizophrenia.

Medical record review of a Minimum Data Set

F 323 -- Resident #8's Care Plan has been reviewed and Fall Prevention Interventions are complete.

The care plans of residents at risk for falls have been reviewed and are complete, with new interventions added after a fall.

The Fall Prevention policy has been reviewed and revised. The RN has re-educated all nursing associates on the need to add a new intervention after each fall.
Continued From page 4

F 323

(MDS) dated June 6, 2012, revealed the resident was moderately impaired with decision-making skills and non-ambulatory, required limited assistance with transfers, and had a history of falls.

Medical record review of a Fall Risk Assessment dated June 7, 2012, revealed a score of eight and included, "...4 or more...will be...care planned at risk..."

Medical record review of the current care plan effective through December 12, 2012, revealed the risk for falls was addressed and interventions included a low bed. Medical record review of a care plan revision dated July 11, 2012, revealed, "...bed pressure sensor..."

Medical record review of a nurse’s note dated September 2, 2012, at 2:45 p.m., revealed, "found...on floor at bedside. Bed low position and bed alarm sounded. No injury...phone call to res (resident’s) son...who requests that both siders be up this evening when res (resident) in bed."

Review of facility investigation dated September 2, 2012, revealed the resident fell out of bed and included, "...were bed rails present yes...R (right) down...successful fall..." Continued review revealed no documentation regarding a new intervention to prevent falls.

Medical record review of a nurse’s note dated September 3, 2012, at 7:45 p.m., revealed, "unwitnessed fall OOB (out of bed)...found lying on floor next to bed by CNA (Certified Nursing Assistant) who was right outside of room and heard bed alarm sound...hematoma to R (right)
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA
IDENTIFICATION NUMBER:
445017

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY
COMPLETED
C
11/05/2012

NAME OF PROVIDER OR SUPPLIER

ASSURY PLACE AT MARYVILLE

STREET ADDRESS, CITY, STATE, ZIP CODE
2848 SEVIERVILLE RD
MARYVILLE, TN 37804

(X4) ID
PREFIX
TAG
SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LCD IDENTIFYING INFORMATION)
F 323
Continued From page 5
forehead and soant blood R nostril...mat placed on floor at this time..." Medical record review of a
nurse's note dated September 3, 2012, at 7:50
p.m., revealed, "...steristrip to small laceration
underneath right nostril..." said doesn't care what state has to say about it. This
could have been prevented. order written per
(Nurse Practitioner-NP for SR (сидерал...)
"

Medical record review of a Nurse Practitioner's
(NP) note dated September 3, 2012, revealed,
"staff report (resident) was in bed with siderail
down...heared noise...went...to check on (resident)
and found in floor on R side...hematoma R
forehead...tiny laceration under R nostril...know
son when he came in...lacerated with soap and
water skin prep (prescription) steristrip..."

Medical record of an Interdisciplinary Narrative
Note dated September 6, 2012, revealed,
"...reevaluated for siderail needs...siderail up per
drs (doctor's) order."

Observations on November 2, 2012, at 3:07 p.m.
and November 5, 2012, at 9:10 a.m., revealed the
resident in bed and the siderails raised.

Interview with the MDS/Care Plan Coordinator on
November 5, 2012, revealed she participated with
review of the resident's falls and she stated,
"...under the impression if successful fall with no
injury there's nothing else we can do at that
point." Continued interview revealed no
additional intervention to prevent falls was
implemented following the resident's fall on
September 2, 2012. Continued interview
confirmed the facility failed to provide adequate
supervision and/or safety device to prevent a fall
### F 323
Continued from page 8 with injury for Resident #8 on September 3, 2012.

C/O: #30415

#### F 441
483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it:
1. Investigates, controls, and prevents infections in the facility;
2. Decides what procedures, such as isolation, should be applied to an individual resident; and
3. Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
1. When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
2. The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
3. The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and
<table>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>F 441</td>
<td>continued from page 7</td>
<td>transport linens so as to prevent the spread of infection.</td>
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</table>

This REQUIREMENT is not met as evidenced by:
- Based on review of facility policy, medical record review, observation, and interview, the facility failed to maintain a sanitary environment to prevent the development and transmission of infection for one resident (#13) of thirteen sampled residents.

The findings included:
- Review of facility policy titled Equipment and Supplies Used During Isolation dated May 22, 2003, revealed, "...supplies will be used to ensure that sanitary conditions are maintained during isolation...shall be stored and maintained in accordance with appropriate isolation precautions..."

Resident #13 was admitted to the facility on August 1, 2012, with diagnoses including Pneumonia.

Medical record review of a laboratory result dated August 10, 2012, revealed, "Clostridium Difficile (C-diff) toxin A+B positive (normal is negative)."

Medical record review of a nurse's note dated August 11, 2012, at 7:00 p.m., revealed, "incontinent bowel @ (at) supper time found stool in floor of room and hallway..."
F 441  Continued From page 8

Medical record review of a nurse’s note dated August 22, 2012, revealed, “to (another floor within the facility)...new order to do (discontinue) isolation with C-diff...” Medical record review of a nurse’s note dated August 22, 2012, at 8:00 p.m., revealed, “wanders into others rooms...gets in other res beds...”

Medical record review of a laboratory report dated September 3, 2012, revealed, “(C-diff) toxin A+B positive...”

Medical record review of a Nurse Practitioner (NP) note dated September 3, 2012, revealed, “seen due to recurrent diarrhea. had just finished (antibiotic) and now with fever...liq (liquid) stool incont.”

Medical record review of a physician’s progress note dated October 8, 2012, revealed recurrent bout with C-diff colitis. has been released from isolation...”

Medical record review of a NP note dated October 11, 2012, revealed, “...still with diarrhea...recurrent C-diff cont (continue) (antibiotic) q4d (four times daily)...through 10-20, then...td (three times daily) x 14 d (for 14 days), then...q12h (every 12 hours) x 14 d, then...qd (every day) x 14 d.”

Observation on November 5, 2012, at 12:48 p.m., revealed a posted sign outside the resident’s room advised visitors to report to the nurse’s station before entering the room.

Observation on November 16, 2012, at 2:33 p.m., revealed the resident seated in a wheelchair and...
<table>
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<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>F 441</td>
<td>Continued From page 9</td>
<td>Fabric heel protectors (worn while in bed) on the floor in the corner of the room. Observation and interview with Licensed Practical Nurse #1 on November 6, 2012, at 2:38 p.m., revealed fabric heel protectors on the floor in the corner of the resident's room and confirmed the facility failed to maintain a sanitary environment to prevent the development or transmission of infection for Resident #13.</td>
<td>C/O: #30363</td>
<td>F 441</td>
<td>Each corrective action should be cross-referenced to the appropriate deficiency.</td>
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