F 164 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS

The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident’s right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident’s records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:

Based on observation and interview, it was determined the facility failed to ensure staff maintained resident privacy when providing care for 1 of 1 (Random Resident #1) random residents; 1 of 1 (Resident #2) residents

This facility will ensure the residents’ rights to personal privacy and confidentiality of his or her personal and clinical records is maintained.

I. All staff will be in-serviced on keeping the privacy curtain, window curtain/blind and door closed when providing care that could expose a resident to anyone entering the room.

II. The facility will ensure the residents’ rights to personal privacy and confidentiality of his or her personal and clinical records is maintained.

This facility will ensure the residents’ rights to personal privacy and confidentiality of his or her personal and clinical records is maintained.

12/1/11

Laboratory Director or Provider/Supplier Representative Signature

[Signature]

Name: ____________________________
Title: ____________________________
Date: ____________
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<tr>
<th>(X1) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X3) COMPLETION DATE</th>
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<tr>
<td>F 164</td>
<td>Continued from page 1 observed during a dressing change and for 1 of 28 (Resident #10) sampled residents observed receiving personal care. The findings included:</td>
<td>F 164</td>
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<td>1. Observations in room 103 on 10/30/11 at 10:25 AM, revealed Random Resident (RR) #1 receiving personal hygiene care from Certified Nursing Assistant (CNA) #5. CNA #5 failed to pull the curtain around RR #1's bed to maintain visual privacy. RR #1's naked body was exposed to anyone coming into the room.</td>
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<td>2. Observation during dressing change in Resident #2's room on 10/31/11 at 10:40 AM revealed the Wound Care Nurse did not close the door during a dressing change.</td>
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<td>3. Observations in Resident #10's room on 10/31/11 at 8:50 AM, CNA #1 did not pull the privacy curtain to maintain privacy during Foley catheter care to Resident #10. Resident #10 was exposed to anyone coming into the room.</td>
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<td>4. During an interview in the A Station Nurse Manager's office on 11/1/11 at 10:30 AM, Nurse #2 was asked about staff ensuring privacy for the residents. Nurse #2 stated, &quot;They [staff] should always pull the curtain whether someone else is in the room or not.&quot;</td>
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<td>F 226 483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES</td>
<td>This facility will develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</td>
<td>12/1/11</td>
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This REQUIREMENT is not met as evidenced by:

Based on policy review and interview, it was determined the facility failed to ensure the resident abuse and neglect policy included 1 of the 7 (prevention component) required components for the prevention of abuse.

The findings included:

- Review of the facility's "RESIDENT ABUSE/NEGLECT OVERVIEW" policy did not document the prevention component to provide residents and families information on how and to whom they may report concerns, incidents and grievances without the fear of retribution; and provide feedback regarding the concerns that have been expressed.

During an interview in the Administrator's office on 11/1/11 at 1:35 PM, the Administration Coordinator was asked to review the "RESIDENT ABUSE/NEGLECT OVERVIEW" policy. The Admission Coordinator stated, "...no, it is not in the policy to provide information to residents and families on how and to whom they report abuse and without fear of retribution."

F 226 Continued From page 2

of resident property. Graceland Nursing Center's Resident Abuse / Neglect Overview was revised on November 09, 2011, to include the following addendum: Addendum to Resident Abuse Neglect Overview:

Residents, family members, consultants, vendors, visitors and any other individuals, who witness, suspect or are aware of any type of abuse or grievance towards a resident of Graceland Nursing Center should report the incident to the Administrator, Director of Nursing or the Nursing Supervisor on duty (the nursing supervisor on duty will report the incident to the Administrator and/or the Director of Nursing). Anyone who reports abuse or a grievance may do so without concern of retribution and will receive feedback once the investigation has been completed.

The Administrator can be contacted at 901-322-0353.

The Director of Nursing can be contacted at 901-322-0357

The Provider Confidential Hotline is 866-355-2995
This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation and interview, it was determined the facility failed to promote care that maintained the resident's dignity, respect and quality of life by requiring the use of a diaper for 1 of 28 (Resident #13) sampled residents observed.

The findings included:
Medical record review for Resident #13 documented an admission date of 5/11/11 with diagnoses of Diabetes Mellitus, Urinary Tract Infection, Hypertension and Status Post Fall. Review of Resident #13's activity of daily living (ADL) flowheets documented Resident #13 wears diapers for urinary incontinence.

Observations in Resident #13's room on 10/30/11 at 10:15 AM and 4:10 PM, on 10/31/11 at 8:15 AM, 2:45 PM and 3:55 PM and on 11/1/11 at 8:30 AM, revealed Resident #13 wearing a diaper.

During an interview on initial tour in Resident #13's room on 10/30/11 at 10:30 AM, Resident #13 stated, "...They don't treat me right, I want to use a urinal, but I have to wear diapers..."

During an interview in Resident #13's room on 11/1/11 at 8:30 AM, Resident #13 was asked if he knew when he needed to urinate, Resident #13 stated, "...Yes..."

During an interview at the A hall nurses' station on 11/1/11 at 8:50 AM, the Restorative Nurse was asked about Resident #13's toileting. The Restorative Nurse stated, "...he does his own..."
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<td>F 241</td>
<td>Continued From page 4 thing...&quot;</td>
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<td>During an interview in the A hall nurse manager's office on 11/1/11 at 9:30 AM, Nurse #4 stated, &quot;...I didn't know he [Resident #13] wanted to use a urinal, we have never tried an urinal... ask restorative nurse about toileting...&quot;</td>
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<td>F 241</td>
<td>This facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</td>
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<td>II. All new admissions will be screened to determine if they are able to use a toilet, urinal or bed side commode. All residents will be screened at least annually by the restorative nurse or designee for toileting abilities.</td>
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<td>III. The restorative nurse will be responsible for checking to ensure new residents are screened for toileting abilities. She will also be responsible for documenting the annual screening for toileting abilities. This will be reported at the Quality Assurance meeting at least quarterly for the next 12 months to ensure interventions are effective.</td>
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F 246, Continued From page 5

F 246 All residents will be provided services in this facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

I. All residents will be assessed for communication abilities during their initial admission assessment. If they are noted to have a hearing impairment they will be referred to Speech Therapy for screening or evaluation. If the resident is unable to understand when someone speaks to them because of decreased hearing ability, they will be provided a white board with marker or a pad and pen/pencil by nursing or Social Services until Speech Therapy makes their recommendation, which will then be followed.

II. All staff will be in-serviced on keeping call lights within reach of a resident in his/her room. The staff will also be instructed to make sure the button is within reach of the hand the resident is most able to use. If the resident is unable to use either hand a head touch activator will be provided.

III. The MDS Director and Social Services Director will monitor to ensure residents...
**Gastrostomy, Dysphagia and Aphasia. Review of the care plan updated 8/16/11 documented, "...Keep call light within reach at all times."**

Observations in Resident #8's room on 10/30/11 at 11:05 AM, revealed Resident #8 lying in the bed. Resident #8's call light signal cord was wrapped around the right headboard post out of reach of the resident. The surveyor pressed the call light and waited in the hall. Facility nursing staff entered the room, checked on the resident and left the room. The surveyor re-entered the room at 11:05 AM. Resident #8's call light remained wrapped around the right headboard post out of reach of the resident.

Observations in Resident #8's room on 10/31/11 at 7:30 AM, 9:30 AM, 10:25 AM, 11:40 AM and 3:40 PM, revealed Resident #8 lying in bed. His call light signal cord was lying on the floor between the headboard and the wall out of reach of the resident.

Observations in Resident #8's room on 10/31/11 at 3:45 PM, Nurse #3 found Resident #8's call light in the floor, handed the call light to the resident, and asked the resident to demonstrate use of the call light. Resident #8 pressed the call light button successfully with his left hand.

During an interview in Resident #8's room on 10/31/11 at 3:46 PM, Nurse #3 was asked about the call light being out of Resident #8's reach, Nurse #3 stated, "...The call light should have been within reach..." Resident #8 nodded his head "yes" when asked if he would like to have the call light to be able to call when he needed help.
The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:

Based on policy review, observation and interview, it was determined the facility failed to maintain an orderly and sanitary environment as evidenced by cracked and torn wheelchair arms and seats, soiled feeding pumps, rusted overbed table and/or brown stain around the base of a commode in 13 of 121 (Rooms 203, 204, 207, 209, 303, 305, 308, 312, 404, 406, 407, 415 and 416) resident rooms observed.

The findings included:

- Review of the facility's "Cleaning Resident Equipment" policy documented, "Resident equipment is to be cleaned in designated areas...as needed."

Observations during initial tour on 10/30/11 beginning at 10:00 AM revealed the following:
- Room 203 - beige substance noted on the base of the feeding pump and the screen.
- Room 204 - beige substance noted on the base of the feeding pump and the screen.
- Room 207 - beige substance noted on the base of the feeding pump and the screen.
- Bathroom adjoining rooms 207 and 209 - brown stain around the base of the commode.
- Room 303 - beige substance noted on the base of the feeding pump and the screen.

This facility will provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior.

#1

For resident rooms 203, 204, 207, 303, 305, 308, 312, 404, 406, 407, 415 and 416, resident rooms observed.

The bathroom adjoining rooms 207 and 209, the brown stain around the base of the commode has been removed. This was completed on November 2nd, 2011.

The bathroom adjoining rooms 207 and 209, the brown stain around the base of the commode has been removed. This was completed on November 2nd, 2011, by the housekeeping staff. In room 404 the left arm of the wheelchair has been replaced and for the other wheelchair in the room; the arm that was wrapped in tape, has been replaced. This was completed by
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<td>F 253</td>
<td>Continued From page 8</td>
<td>f. Room 305 - beige substance noted on the base of both feeding pumps and screens.</td>
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<td>maintenance staff on November 3rd, 2011.</td>
<td>12/1/11</td>
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<td>g. Room 308 - beige substance noted on the base of the feeding pump and the screen.</td>
<td>In room 407, the overbed table has been replaced. This was completed by maintenance staff on November 3rd, 2011.</td>
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<td>h. Room 312 - beige substance noted on the base of the feeding pump and the screen.</td>
<td>in room 416, the wheelchair seat has been replaced. This was completed by maintenance staff on November 4th, 2011.</td>
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<td>i. Room 404 - beige substance noted on the base of the feeding pump and the screen, left arm of a wheelchair torn, and the other wheelchair had an arm wrapped in black electrical tape that was peeling.</td>
<td>#2 For feeding pumps, wheelchairs, overbed tables, commodes and other resident equipment, a facility wide audit was conducted to determine if there was other equipment that had not been maintained in an &quot;orderly, sanitary and comfortable&quot; manner. The audit was conducted on November 8th and 9th by Maintenance Director and Housekeeping Director. Any items identified were corrected by the appropriate department, either the Maintenance or Housekeeping by November 15th, 2011.</td>
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<td>j. Room 405 - beige substance noted on the base of the feeding pump.</td>
<td>k. Room 407 - base of the overbed table was rusted.</td>
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<td>l. Room 415 - beige substance noted on the base of the feeding pump and the screen.</td>
<td>m. Room 416 - wheelchair seat was torn and frayed.</td>
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During an interview in room 415 on 11/1/11 at 4:15 PM, Nurse #3 was asked about the dirty feeding pump. Nurse #3 stated, "It needs to be cleaned. Nurses and Nurse Managers are responsible for cleaning the equipment in the rooms."

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation
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<td>F 282</td>
<td>Continued From page 9</td>
<td>and interview, it was determined the facility failed to follow the care plan for floating heels to prevent skin breakdown or bathing for 2 of 28 (Residents #10 and 13) sampled residents. The findings included: 1. Medical record review for Resident #10 documented an admission date of 10/17/11 and a readmission date of 10/25/11 with diagnosis of Diabetes Mellitus, Muscle Weakness, Osteoarthritis, Anemia, Spinal Cord Compression Lumbar [L] 4 - L5 canal obstruction, Chronic Kidney Disease Stage 4, Quadriplegia and Hypertension. Review of the physician's orders dated 10/17/11 documented, &quot;...Float Bil [bilateral] heels @ [at] all times...&quot; Review of the care plan updated 10/28/11 documented, &quot;...Float Bil heels at all times...&quot; Observations in Resident #10's room on 10/31/11 at 8:25 AM, 11:10 AM, 12:30 PM and 12:40 PM, revealed Resident #10's bilateral heels were not floated while in the bed as care planned. During an interview in Resident #10's room on 10/31/11 at 12:40 PM, Nurse #1 stated, &quot;...no, they [Resident #10's heels] are not floated...&quot; 2. Medical record review for Resident #13 documented an admission date of 5/11/11 with diagnoses of Diabetes Mellitus, Urinary Tract Infection, Hypertension and Status Post Fall. Review of Resident #13's care plan updated 8/28/11 documented Resident #13 to have showers twice weekly. Review of Resident #13's Activities of Daily Living (ADL) flowsheet documented only one shower given (10/14/11) for</td>
<td>#3</td>
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The Social Work Director will conduct random monthly audits of resident equipment, i.e. feeding pumps, wheelchairs, overbed tables, resident bathrooms and other resident equipment to ensure that a "sanitary, orderly and comfortable" environment is being provided. Any items identified as not being "sanitary, orderly or comfortable" will be repaired or replaced by the appropriate department. The Social Work Director will ensure that the corrective action occurs.

#4

The Social Work Director will report the findings of the monthly assessment of resident equipment being "sanitary, orderly and comfortable" as a part of the facility Quarterly Assurance Program.
Continued from page 10, the other days documented bed baths.

During an interview on the initial tour, in Resident #13's room on 10/30/11 at 10:30 AM, Resident #13 stated, "I can't walk... they don't give me baths regularly... I can't do it myself..."  

During an interview in Resident #13's room on 11/1/11 at 8:30 AM, Resident #13 stated, "I haven't gotten over eight showers since I've been here in May [2011]..."

During an interview outside of the shower room on A Hall on 11/1/11 at 8:15, certified nursing assistant (CNA) #6 stated, "...he [Resident #13] doesn't refuse showers..."

During an interview in the A Hall nurse manager's office on 11/1/11 at 9:30 AM, Nurse #4 shook her head after being informed only one shower was documented the month of October 2011.

The services provided or arranged by this facility will be provided by qualified persons in accordance with each resident's written plan of care.

1. The CNA daily assignment sheet will include any special needs/instructions/orders, including but not limited to floating heels, from the plan of care and/or physician's orders.

2. All nursing staff will be in-serviced on:
   All residents will be offered a shower or whirlpool at least twice per week unless ordered differently by the physician/practitioner. If a resident requests bathing more frequently than twice per week, this request will be accommodated.

3. Nurse managers, the DON or their designee will check to make sure heels are floated as ordered during rounds at least twice per week.

4. The CNA ADL flow sheet has been modified to give a more accurate record of resident baths. The nurse managers will check the bath logs at least twice per week to ensure baths are being given. If a resident refuses a bath the CNA must report this to the nurse, who will make an entry in the nursing notes. If a resident refuses more than 2 consecutive baths...
F 309 Continued From page 11

physician's orders for notification of blood sugars greater than 250 three times a week for 2 of 8 (Residents #2 and 15) sampled diabetic residents receiving sliding scale insulin.

The findings included:

1. Medical record review for Resident #2 documented an admission date of 1/3/11 and a readmission date of 4/29/11 with diagnosis of Diabetes Mellitus, Cerebrovascular Accident, Atrial Fibrillation and Pneumonia. Review of a physician's "Standing Orders" documented, "...If blood sugars [BS] are greater than 250 mg [milligrams] / [per] dl [deciliter] three or more times per week, notify MD [medical doctor]..."


Review of Resident #2's daily skilled nurses notes for June 2011 contained no documentation of the MD being notified of BS greater than 250 mg/dl.

Review of Resident #2's diabetic control sheet for July 2011 documented the following blood sugar results: 7/2 - 262, 7/3 - 272, 7/4 - 277, 7/9 - 272, 7/10 - 308 and 7/11 - 283.

Review of Resident #2's daily skilled nurses notes for July 2011 contained no documentation that the MD was notified of the BS greater than 250mg/dl.

F282 the physician or practitioner will be notified.

V. This will be reported on at the Quality Assurance meeting at least quarterly for the next 12 months to ensure interventions are effective.

F309 Each resident will receive and this facility will 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.

I. All Graceland nurses will be in-serviced on the requirement to notify the physician/practitioner if any resident's blood glucose is greater than 250 mg/dl 3 times in 1 week. They will indicate the physician was notified on the diabetic monitoring sheet and also make an entry in the nursing notes that notification was made.

II. The consultant pharmacist will review glucose monitoring sheets quarterly.

III. The nurse managers or designee will review all glucose monitoring sheets at least twice per week to ensure the physician/practitioner has been notified.
F 309 Continued From page 12

Review of Resident #2's diabetic control sheet for August 2011 documented the following blood sugar results: 8/1 - 269, 8/2 - 308, 8/3 - 323, 8/4 - 283, 8/6 - 261, 8/10 - 268, 8/15 - 284, 8/19 - 288, 8/21 - 289, 8/24 - 267, 8/25 - 277, 8/26 - 303, 8/28 - 263 and 8/31 - 340.

Review of Resident #2's daily skilled nurses notes for August 2011 contained no documentation that the MD was notified of the BS greater than 250mg/dl.


Review of Resident #2's daily skilled nurses notes for September 2011 contained no documentation that the MD was notified of the BS greater than 250mg/dl.

Review of Resident #2's diabetic control sheet for October 2011 documented the following blood sugar results: 10/10 - 301, 10/11 - 254, 10/13 - 282, 10/16 - 251, 10/18 - 256, 10/19 - 251, 10/20 - 271, 10/23 - 269, 10/24 - 304, 10/27 - 279, 10/28 - 310 and 10/30 - 281.

Review of Resident #2's daily skilled nurses notes for October 2011 contained no documentation that the MD was notified of the BS greater than 250mg/dl.

of any resident's blood glucose levels greater than 250 3 times in one week.

IV. This will be reported on at the Quality Assurance meeting at least quarterly for the next 12 months to ensure interventions are effective.
2. Medical record review for Resident #15 documented an admission date of 3/24/10 with diagnosis of Diabetes Mellitus, Hypertension and Dementia. Review of a physician's recertification orders dated 7/1/11 - 7/31/11 signed 7/12/11, recertification orders dated 8/1/11 - 8/31/11 signed 8/2/11, recertification orders dated 9/1/11 - 9/30/11 signed 9/3/11 and recertification orders dated 10/1/11 - 10/31/11 signed 10/4/11 documented, "...if blood sugars [BS] are greater than 250 mg [milligrams]/dl [deciliter] three or more times per week, notify MD.


Review of Resident #15's daily skilled nurses notes for July 2011 contained no documentation that the MD was notified of the BS greater than 250mg/dl.


Review of Resident #15's daily skilled nurses notes for August 2011 contained no documentation that the MD was notified of the BS greater than 250mg/dl.

Review of Resident #15's diabetic control sheet
Continued From page 14


Review of Resident #15's daily skilled nurses notes for September 2011 contained no documentation that the MD was notified of the BS greater than 250mg/dl.

Review of Resident #15's diabetic control sheet for October 2011 documented the following blood sugar results: 10/2 - 394, 10/3 - 265, 10/5 - 346, 10/14 - 311, 10/15 - 284, 10/19 - 347, 10/20 - 315, 10/23 - 268, 10/24 - 275, 10/27 - 296, 10/28 - 362, 10/29 - 296, 10/30 - 305 and 10/31 - 262.

Review of Resident #15's daily skilled nurses notes for October 2011 contained no documentation that the MD was notified of the BS greater than 250mg/dl.

During an interview at the A nurses' station on 11/1/11 at 8:40 AM, Nurse #2 confirmed Resident #15 had a physician's order for notification if BS greater than 250mg/dl three or more times per week. Nurse #2 confirmed there was no documentation of the physician being notified of BS greater than 250mg/dl for July, August, September and October 2011. Nurse #2 stated, "...yes, I see the BS are 250mg or above and the order states notify the MD...I see no notification of the MD in the nurses notes or telephone orders...I expect the MD to be notified and documented in the nurses notes..."
F 312. Continued From page 15
A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it was determined the facility failed to provide care and services of a shower twice a week for 1 of 28 (Resident #13) sampled residents observed.

The findings included:

Medical record review for Resident #13 documented an admission date of 5/11/11 with diagnoses of Diabetes Mellitus, Urinary Tract Infection, Hypertension and Status Post Fall. Review of the certified nurse aide (CNA) assignment sheet documented Resident #13 was to have showers every Monday and Thursday.

Review of Resident #13's Activities of Daily Living (ADL) flowsheet documented only one shower given (10/14/11) for the month of October 2011, the other days documented bed baths.

During an interview on the initial tour, in Resident #13's room on 10/30/11 at 10:30 AM, Resident #13 stated, "...I can't walk... they don't give me baths regularly... I can't do it myself..."

During an interview in Resident #13's room on 11/1/11 at 8:30 AM, Resident #13 stated, "...I haven't gotten over eight showers since I've been here in May [2011]..."
F 312  Continued From page 16

During an interview outside of the shower room on A Hall on 11/11/11 at 9:15, CNA #6 stated, "...he [Resident #13] doesn't refuse showers."

During an interview in the A Hall nurse manager's office on 11/11/11 at 9:30 AM, Nurse #4 shook her head after being informed only one shower was documented the month of October 2011.

F 314  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 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.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation and interview, it was determined the facility failed to follow their care plan to prevent or promote healing of pressure ulcers for 2 of 7 (Residents #2 and 10) sampled residents with or at risk for pressure ulcers.

The findings included:

1. Medical record review for Resident #2 documented an admission date of 1/3/11 with a readmission date of 4/29/11 with diagnoses of Cerebrovascular Accident, Atrial Fibrillation,
F 314 Continued From page 17

- Decubitus Ulcer, Percutaneous Esophageal Gastrostomy (PEG), Pneumonia, Diabetes Mellitus, Pulmonary Embolism (PE) and Osteomyelitis. Review of the care plan dated 1/18/11 documented, "...potential for skin breakdown..." perform/document weekly systemic skin assessment." Review of the skin assessments dated 1/3/11 to 2/2/11 documented that skin assessments were not documented consistently, with the only documented skin assessment on 2/18/11. Nurses notes documented Resident #2 was sent to the emergency room with a mental status change on 2/21/11, and skin was intact at that time. Resident #2 was transported from the facility by ambulance personnel at 12:26 PM to the emergency room. Resident #2 returned to the facility on 2/21/11 at 10:00 PM. The facility staff failed to document a complete skin assessment when Resident #2 returned to the facility. The skin assessment was not documented as being done until 2/22/11 at 9:00 AM, and Resident #2 was found to have a stage III decubitus ulcer to the sacrum.

Observations in Resident #2's room on 10/30/11 at 10:30 AM, revealed Resident #2 was totally dependent for care and was unable to turn and reposition herself.

During an interview in the admission Director's office on 10/31/11 at 4:00 PM, the Director of Nursing (DON) was asked if the facility nurse had performed a skin assessment on return from the emergency room on 2/21/11. The DON stated "Yes". The facility was unable to provide documentation of a skin assessment that was completed upon return to the facility on 2/21/11.

F 314 needs/instructions/orders, including but not limited to floating heels, from the plan of care and/or physician's orders.

V. Nurse managers, the DON or their designee will check to make sure heels are floated as ordered during rounds at least twice per week.

V. This will be reported on at the Quality Assurance meeting at least quarterly for the next 12 months to ensure interventions are effective.
F 314 | Continued From page 18

During an interview in the admissions office on 1/11/11 at 10:00 AM, the DON and Administrator were asked about the delay in time when Resident #2 returned to the facility after the emergency room visit on 2/21/11 and the skin assessment. The DON stated, "...did poor job of documentation..." The surveyor asked if a skin assessment should have been performed upon the return to the facility. The DON and Administrator both said, "Yes."

During an interview in the admission Director's office on 11/11/11 at 1:30 PM, Resident #2's physician stated that he had probably seen Resident #2's skin on admission because he had a diligent student with him. Resident #2's physician was asked if there was a darkened area to the sacrum prior to the emergency room visit on 2/21/11. The physician stated, "No."

2. Medical record review for Resident #10 documented an admission date of 10/17/11 and a readmission date of 10/25/11 with diagnosis of Diabetes Mellitus, Muscle Weakness, Osteoarthritis, Anemia, Spinal Cord Compression Lumbar (L) 4 and L5 canal obstruction, Chronic Kidney Disease Stage 4, Quadriplegia and Hypertension. Review of the physician's orders dated 10/17/11 documented, "... FLOAT BITT [bilateral] heels @ [at] all times..."

Observations in Resident #10's room on 10/31/11 at 8:25 AM, 11:10 AM, 12:30 PM and 12:40 PM revealed Resident #10's bilateral heels were not floated while in the bed.

During an interview in Resident #10's room on 10/31/11 at 12:40 PM, Nurse #1 pulled back the
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

#### Provider/Supplier/Clinic Identification Number:
445331

#### Multiple Construction
- A. Building
- B. Wing

#### Date Survey Completed
11/01/2011

### NAME OF PROVIDER OR SUPPLIER
GRACELAND NURSING CENTER

### STREET ADDRESS, CITY, STATE, ZIP CODE
1250 FARROW ROAD
MEMPHIS, TN 38116

### ID PREFIX TAG

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSO identifying information)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER’S PLAN OF CORRECTION (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 314</td>
<td>Continued From page 19 bed linen to reveal Resident #10’s feet. Nurse #1 stated, &quot;...no, they [Resident #10’s heels] are not floated...&quot;</td>
<td></td>
<td>F 314</td>
<td>12/1/11</td>
</tr>
<tr>
<td>F 322 SS-D</td>
<td>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</td>
<td></td>
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<td>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on medical record review, observation and interview, it was determined the facility failed to ensure the physician’s order was followed regarding the amount of flush ordered for 1 of 5 (Resident #21) sampled residents with Percutaneous Endoscopy Gastrostomy (PEG) tubes.</td>
<td></td>
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<td></td>
<td>The findings included:</td>
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</table>
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

<table>
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<tr>
<th>Statement of Deficiencies and Plan of Correction</th>
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<td>(X1) Provider/Supplier/Clinic Identification Number: 445331</td>
</tr>
<tr>
<td>(X2) Multiple Construction</td>
</tr>
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<td>A. Building</td>
</tr>
<tr>
<td>B. Wing</td>
</tr>
<tr>
<td>(X3) Date Survey Completed: 11/01/2011</td>
</tr>
</tbody>
</table>

**Name of Provider or Supplier**  
Graceland Nursing Center  
**Street Address, City, State, Zip Code**  
1250 Farrow Road  
Memphis, TN 38116

<table>
<thead>
<tr>
<th>(X4) ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>(X5) Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 322</td>
<td>Continued From page 20 Observations in Resident #21's room on 11/1/11 at 8:15 AM and 9:40 AM, revealed the NS flush infusing at 30 cc per hour. During an interview at B nurses' station on 11/1/11 at 9:45 AM, Nurse #3 confirmed the NS infusion rate was infusing at 30 cc per hour. During an interview in the Administrator's office on 11/1/11 at 11:20 AM, the Director of Nursing confirmed the NS should be infusing at 60 cc per hour.</td>
<td>F 322</td>
<td></td>
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<tr>
<td>F 323</td>
<td>483.25(h) Free of Accident Hazards/Supervision/Devices</td>
<td>F 323</td>
<td>This facility will 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.</td>
<td>12/1/11</td>
</tr>
<tr>
<td>SSNd</td>
<td>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.</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, it was determined the facility failed to prevent a fall for 1 of 5 (Resident #2) sampled residents identified with falls. The findings included: Review of the facility's &quot;Falls Risk Assessment / Interventions&quot; documented, &quot;...all residents will have a falls risk assessment after any fall... Bed-side mats...&quot;</td>
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**Event ID:** DBE611  
**Facility ID:** TN7999  
**If continuation sheet:** Page 21 of 33
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLA Identification Number:**
445331

**Address:**
1250 Farrow Road
MEMPHIS, TN 38116

<table>
<thead>
<tr>
<th>Deficiency Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 323</td>
<td>Continued From page 21</td>
</tr>
<tr>
<td></td>
<td>Medical record review for Resident #2 documented an admission date of 1/13/11 with a re-admission date of 4/29/11 with diagnoses of Cerebrovascular Accident, Decubitus Ulcer, Percutaneous Endoscopy Gastrostomy, Pneumonia, Diabetes Mellitus, Pulmonary Embolism, and Osteomyelitis. Review of the care plan dated 1/3/11 documented Resident #2 as a high risk for falls due to immobility. Review of a nurse’s note dated 3/6/11 documented, ”...found lying face down on floor.”</td>
</tr>
<tr>
<td>F 323</td>
<td>III. Any resident on a low air loss or alternating pressure mattress will be checked by the charge nurse every 4 hours for proper positioning, in addition to being checked every 2 hours by the CNAs.</td>
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<td></td>
<td>IV. This will be reported on at the Quality Assurance meeting at least quarterly for the next 12 months to ensure interventions are effective.</td>
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</table>

**Provider’s Plan of Correction**

<table>
<thead>
<tr>
<th>Date of Completion</th>
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<tbody>
<tr>
<td>12/1/11</td>
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</table>

**The facility must ensure that residents receive proper treatment and care for the following:**
This facility will ensure that residents receive proper treatment and care for the following special services: injections; parenteral and enteral fluids; colostomy, ureterostomy, or ileostomy care; tracheostomy care; tracheal suctioning; respiratory care; foot care; and prostheses.

I. All hypodermoclysis (clysis) in this facility will be run on an IV pump to help ensure accuracy. The nurse manager or supervisor will check each resident receiving clysis at least once per shift to ensure the fluids are infusing at the correct rate and the amount of fluids remaining in the bag are correct related to the time the fluids were hung and the run rate. If an incorrect rate is found, or the remaining fluids are incorrect, the physician or practitioner will be notified.

II. Each resident receiving clysis will have the access site reviewed and documented at least once per shift by the charge nurse or supervisor. If any problems are noted to the site the fluids will be stopped and the physician or practitioner will be notified immediately.

III. All IV fluids will be changed every 24 hours unless a different time is specified by the pharmacy or manufacturer.
<table>
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<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LGC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
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<tbody>
<tr>
<td>F 328</td>
<td>Continued From page 23</td>
<td>10/26/11 - all three shifts of nurses, 10/29/11 - 11:00 PM to 7:00 AM shift, 10/30/11 - 11:00 PM to 7:00 AM and 3:00 PM to 11:00 PM shifts and 10/31/11 - 11:00 PM to 7:00 AM and 3:00 PM to 11:00 PM shifts. Observations in Resident #1's room on 10/30/11 at 10:30 AM, revealed a bag of NS dated 10/29/11 hung at 3:00 PM with 300 cc of fluid left in it infusing into Resident #1. If the NS was infusing as ordered by the physician, the bag of NS should have finished infusing by approximately 8:30 AM on 10/30/11. Observations in Resident #1's room on 10/30/11 at 3:35 PM, revealed the same bag of NS was hanging with 700 cc of fluid left in the bag. In 5 hours and 45 minutes only 100 cc of fluids had infused. If infusing at the ordered rate 345 cc of NS should have infused. During an interview in the conference room on 11/1/11 at 3:00 PM, the Development Coordinator was asked about the bag of NS hanging for more than 24 hours. The Development Coordinator stated, &quot;I would expect the bag to be changed every 24 hours as per IV fluid procedures.&quot; The Development Coordinator was asked how often the bag of fluid should be checked for proper flow rate. The Development Coordinator stated, &quot;Once per shift.&quot;</td>
<td>IV. This will be reported on at the Quality Assurance meeting at least quarterly for the next 12 months to ensure interventions are effective.</td>
<td>12/1/11</td>
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<tr>
<td>F 334</td>
<td>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS</td>
<td>The facility must develop policies and procedures that ensure that— (I) Before offering the influenza immunization, each resident, or the resident's legal</td>
<td>12/1/11</td>
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F 334: Continued From page 24
representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

The facility must develop policies and procedures that ensure that—
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes

F 334: resident's legal representative receive education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of the influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

This facility's policies and procedures will ensure that—
(i) Before offering the pneumococcal immunization each resident or the resident's legal representative receive education regarding the benefits and potential side effects of the immunization:
Continued from page 25 documentation that indicated, at a minimum, the following:

(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization, and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it was determined the facility failed to document administration or refusal of the pneumococcal vaccination and the influenza vaccination for 1 of 26 (Resident #2) sampled residents.

The findings included:

Medical record review for Resident #2 documented an admission date of 1/3/11 with diagnoses of Cerebrovascular Accident, Atrial Fibrillation, Decubitus, Pneumonia, Diabetes Mellitus, Pulmonary Embolus and Osteomyelitis. Medical record review

(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of the pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the influenza immunization due to medical contraindications or refusal.
(v) As an alternative, based on assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or resident's legal representative refuses the second immunization.
1. The admissions coordinator or designee will find out from the resident, family or hospital if any new admit resident has
<table>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>F 334</td>
<td>Continued From page 26</td>
<td>483</td>
<td>documented permission from the Power of Attorney (POA) to administer the influenza vaccination and the pneumococcal vaccination to Resident #2. Review of the Minimum Data Set (MDS) documented under &quot;...Section O0250... Did the resident receive the influenza vaccine in this facility... 0. No... Not offered... Section O0300... If not pneumococcal vaccine not received, state reason... Not offered...&quot;</td>
<td>483</td>
<td>65</td>
<td>INFECTION CONTROL, PREVENT SPREAD, LINENS</td>
<td>received the influenza or pneumococcal immunization, if records of the immunizations/s are available they will be added to the resident's medical record here. If no records are available, the resident, family member or hospital staff inform the admissions coordinator/designee that influenza or pneumococcal immunization were given, she/he will document this in the admission packet sheet designated for immunization Information.</td>
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**F 334**

| | | | | | | | |

**SS-D**

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
F 441 Continued From page 27

- Isolate the resident.
  1. 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.
  2. The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.
  3. Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

Based on policy review, observation and interview, it was determined the facility failed to ensure 1 of 9 (Nurse #4) medication nurses maintained hand hygiene during medication administration and 3 of 17 certified nursing assistants (CNA #2, 3 and 4) maintained hand hygiene or handle food with bare hands during dining observations.

The findings included:

1. Review of the facility's "Handwashing/Hand Hygiene" policy documented, "...Before and after direct contact with residents... After contact with objects in the immediate vicinity of the resident..."

2. Observations in resident room 508 on 10/30/11 at 4:00 PM, Nurse #4 administered medication to the resident and left the room.
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTER FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/ SUPPLIER/ MANUFACTURER IDENTIFICATION NUMBER: 445331

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED 11/01/2011

NAME OF PROVIDER OR SUPPLIER
GRACELAND NURSING CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1250 FARRAR ROAD
MEMPHIS, TN 38116

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISO IDENTIFYING INFORMATION)  
ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  
(X5) COMPLETION DATE

F 441 Continued From page 28 without performing any hand hygiene.

3. Observations of meal tray pass in room 209 on 10/31/11 at 12:15 PM, CNA #2 washed her hands, but turned the water faucet off with her wet hands.

4. Observations of meal tray pass in room 215 on 11/31/11 at 12:30 PM, CNA #3 picked up a roll from resident’s tray with her bare hands.

5. Observations of meal tray pass in room 611 on 10/31/11 at 7:53 AM, CNA #4 picked up the toast bare handed and applied jelly without washing her hands.

Observations of meal tray pass in room 612 on 10/31/11 at 7:57 AM, CNA #4 held the boiled egg with the left hand, picked up the toast bare handed to apply butter and jelly.

Observations of meal tray pass in room 617 on 10/31/11 at 8:00 AM, CNA #4 picked up the toast bare handed and applied butter and jelly.

6. During an interview in the Director of Nursing's (DON) office on 11/1/11 at 3:15 PM, the DON was asked what his expectations were regarding hand hygiene and meal tray pass. The DON stated, “Before and after patient contact... if the patient or environment are touched... and wash hands after every third tray... not acceptable to touch the food with bare hands...”

F 441 The facility has established and will maintain an infection control program designed to provide a safe, sanitary and comfortable environment and prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility will 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
(2) The facility will 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 requires staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

I. All staff will be in-serviced on when it is necessary to wash their hands in providing care and services to residents in this facility. The nurses and CNAs will also be in-serviced on the correct way to set

F 455 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON

The facility must provide a safe, functional,
F 465 Continued From page 29

sanitary, and comfortable environment for residents, staff and the public.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure the environment was clean and sanitary as evidenced by scarred door frames and walls in 11 of 121 resident rooms (rooms 207, 213, 215, 217, 300, 302, 304, 306, 308, 310 and 312) and the walls on 1 of 4 (300 hall) halls were marked with blue or black marks.

The findings included:

Observations of the facility during the initial tour on 10/30/11 beginning at 10:00 A.M. revealed the following:
a. Room 207 - Left door frame scarred on lower four feet facing hall.
b. Room 213 - Left and right door frame scarred on lower three feet facing hall.
c. Room 215 - Left and right door frame scarred on lower four feet facing hall.
d. Room 217 - Left and right door frame scarred on lower two feet facing hall.
e. Room 300 - Left and right door frame scarred on lower three feet facing hall.
f. Room 302 - Left and right door frame scarred on lower three feet facing hall.
g. Room 304 - Left and right door frame scarred on lower four feet facing hall.
h. Room 306 - Left and right door frame scarred on lower three feet facing hall.
i. Room 308 - Left and right door frame scarred on lower three feet facing hall.

F 465 The facility will provide a safe, functional, sanitary and comfortable environment for residents, staff and the public.

For resident rooms 207, 213, 215, 217, 300, 302, 304, 306, 310 and 312 the door frames have been painted. For the wall

F 441 up a tray without touching food with their bare hands.

II. Nurse managers and supervisors will check for proper hand washing during rounds at meal times at least twice per week. This will include meal service on the halls as well as both dining rooms.

III. Graceland nurses who administer medications will be observed for proper hand washing during medication pass by nurse manager and supervisor rounds at least twice per week. Additionally, nurses will have hand washing included in their quarterly med pass reviews.

IV. This will be reported on at the Quality Assurance meeting at least quarterly for the next 12 months to ensure interventions are effective.

12/1/11

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F 465
- ❍ Room 310 - Left door frame scarred on lower two feet; right door frame scarred on lower four feet facing hall.
- ❍ Room 312 - Left and right door frame scarred on lower two and one half feet facing hallway.
- ❍ Walls above and below the handrail between rooms 300 and 302 and between room 302 and 304 were marred with black marks and the walls above and below the handrail between rooms 306 and 308 were marred with black and dark blue marks.

During the interview in the conference room on 11/1/11 at 5:00 PM, the Administrator acknowledged there were environmental issues.

F 465
- above and below the handrail between rooms 300 and 302 and 302 and 304, the walls have been painted. The maintenance staff repainted all of the door frames in the building beginning on November 9th, 2011 and ending on November 14th, 2011.
- The Maintenance Director and Administrator, on November 14, 2011 walked the facility to identify any walls near resident rooms that had markings or signs that the area needed to be painted. Any areas identified will be painted by November 18th, 2011. The Maintenance Director will on a monthly basis make random rounds throughout the facility to identify door frames and walls in need of paint or repair. Any identified areas will be painted and or repaired when identified.
- The results of the Maintenance Director's rounds will be included in the facility's Quality Assurance Program.

F 514
- Records-Complete/Accurate/Accessibl

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:

- Based on medical record review, observation and interview, it was determined the facility failed to ensure the accuracy of documentation in the
F 514 Continued From page 31
medical record for 2 of 28 (Residents #16 and 22) sampled residents.

The findings included:


During an interview at the B nurses' station on 10/31/11 at 3:40 PM, Nurse #3 stated, "...The hospice order should be carried over [from] recertification to recertification [orders]..."

2. Medical record review for Resident #22 documented an admission date of 12/26/04 with a readmission date of 9/23/10 with diagnoses of Congestive Heart Failure, Chronic Kidney Disease, Alzheimer's and Gastrostomy. Review of a physician's order dated 3/16/11 documented, "...Change tube feeding... Nutren Pulmonary 45 cc [cubic centimeters] [per] hr [hour] x [times] 22 H [hours]..." Review of the physician's recertification orders dated 10/4/11 documented, "...NUTREN PULMONARY @ [at] 45CC/HR x22hr..." Review of the "DIETARY PROGRESS NOTES" dated 8/3/11, 8/31/11 and 10/5/11 documented, "...Nutren Pulmonary @ 65 cc/hr x 22 hrs..."

Observations in Resident #22's room on 11/1/11 at 8:10 AM and 1:40 PM, revealed Resident #22

This facility will 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 will 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.

I. Nurse managers or their designee will review the physician's recertification sheets for accuracy each month before the sheets are placed on the medical record. Any discrepancies will be corrected. The pharmacy will be notified of the errors so that the next ones printed will be accurate.

II. The dietitian will assess each resident monthly that receives gastrostomy feedings and document an accurate progress note to reflect their condition.

III. Medical records will perform a chart audit monthly on each of the nursing units that will include, but not be limited to, checking the physician's recertification sheet and dietary progress notes for accuracy.
**Statement of Deficiencies and Plan of Correction**

**Step 514**

**Summary Statement of Deficiencies**

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**F 514**

was receiving Nutren Pulmonary tube feeding infusing at 45 cc/hr.

During an interview at the A nurses' station on 11/1/11 at 11:00 AM, the Nurse Practitioner stated, "...the tube feedings were decreased in March [2011] due to fluid and respiratory issues...she [Resident #22] is doing well and is better from a pulmonary standpoint with the feeding at 45 cc/hr..." The Registered Dietitian (RD) was asked about the discrepancy between the physician's orders, the observed rate of infusion of the tube feeding and the RD notes. The current RD stated, "I don't know what she [former RD] was thinking."

**Provider's Plan of Correction**

IV. This will be reported on at the Quality Assurance meeting at least quarterly for the next 12 months to ensure interventions are effective.

**Completion Date**

12/1/11

**Received**

Nov 18 2011