### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/Client Identification Number:** 445220

**Provider:** SPRING GATE REHAB & HEALTHCARE CENTER

**Street Address, City, State, Zip Code:** 3909 COVINGTON PIKE, MEMPHIS, TN 38135

<table>
<thead>
<tr>
<th>(x0) ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>(x0) ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should be Cross-Referenced to the Appropriate Deficiency)</th>
<th>(x0) Completion Date</th>
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<tbody>
<tr>
<td>F 225 SS=4056</td>
<td>483.13(c)(1)(ii)-(III), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</td>
<td>F 225</td>
<td>This provider submits the following plan of correction in good faith and to comply with Federal Law. This plan is not an admission of wrong doing nor does it reflect agreement with the facts and conclusions stated in the statement of deficiencies.</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>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>
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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>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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**Signature:**

**Title:** ADMINISTRATOR

**Date:** 7/3/2010

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Any deficiency statement ending with an asterisk (*) indicates 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 dischargeable 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 dischargeable 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.

The provider POC is: FREDERICK L. HAYES 7/21/10
**F 225** Continued From page 1  
This REQUIREMENT is not met as evidenced by:  
Based on medical record review, review of an incident report and interview, it was determined the facility failed to thoroughly investigate an unusual incident in which a resident was rolled out of the bed for 1 of 31 (Resident #10) sampled residents.

The finding included:

Medical record review for Resident #10 documented an admission date of 2/1/07 and readmission date of 10/8/08 with diagnoses of Cerebral Thrombosis, Coronary Artery Disease, Gastrostomy, Diabetes, Hypertension, Febrile Convulsions, Dysphagia, Senile Dementia, Intracerebral Hemorrhage and Chronic Kidney Disease. Review of the Minimum Data Set dated 3/3/10 documented the resident had short and long-term memory problems and was moderately impaired in decision making. She was assessed as total dependence with transfers, activities of daily living, and eating.

Review of the Condition Change Form taped to the Nurse’s Notes dated 3/30/10 at 8:10 AM documented “CNA [Certified Nursing Assistant] was giving resident a bath + [and] turned resident over, resident fell out of bed on rt [right] side of body...”

Review of the Accident Report dated 3/31/10 documented “Resident was receiving ADL [Activities of Daily Living] care + rolled out of bed when being turned... Yes, 1/4 side rail were present...”

During an interview in the conference room on...
Continued from page 2

6/16/10 at 2:40 PM, the Director of Nursing (DON) stated, "This is all of the investigation on Resident #10 (referring to the information as noted above). The DON was for the original copy of the accident report and the 4/1/10 in-service. The DON stated, "We cannot find it."

The facility was unable to provide a complete and thorough investigation of Resident #10's 3/30/10 incident.

F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

The facility must 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.

This REQUIREMENT is not met as evidenced by:

Based on observation and interview, it was determined the facility failed to ensure 1 of 28 (Resident #21) observed sampled residents dignity was maintained when staff failed to remove a sticker size tag from the resident's shirt.

The findings included:

Observations in Resident #21's room on 6/16/10 at 9:55 AM, revealed Resident #21 dressed in a shirt and pants with a size sticker approximately 6 inches long still attached to the front of her shirt.

During an interview in the magnolia room on 6/16/10 at 10:10 AM, the Social Worker (SW) was asked if it was appropriate for the staff not to remove size stickers from new clothing when assisting a resident that required help with

For resident # 21, the sticker was removed from her shirt. When the resident was interviewed she denied having negative feelings over the incident.

On 6-17-10, residents who were in house were checked to determine if there were any visual labels attached to their clothing; none were found.

Re-education will be conducted by Unit Managers on or before 7-14-10 nurses and CNAs regarding removing clothing stickers or labels of any kind from resident's clothing before putting clothing on residents.

Social Services will do random audits of 20 residents weekly to determine if there are residents with new clothing with clothing stickers of any kind that need to be removed.

The findings of the audits will be brought to the monthly Quality Assurance and Assessment (QA&A) meeting by Social Services or designee and reviewed for 3 months.
**Continued From page 3**

F 241  dressing. The SW stated, "...the size sticker should not have been left on the shirt."

F 250  483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE

**The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.**

This REQUIREMENT is not met as evidenced by:
- Based on review of the Social Worker's (SW) job description, medical record review, observations and interviews, it was determined the facility failed to provide social services for grief support and/or implement interventions to obtain eyeglasses for 2 of 28 (Residents #13 and 20) sampled residents observed.

The findings included:

1. Review of the SW's job description documented, "Summary: Provides psychosocial support to residents and their families... Essential Functions: Provides direct psychosocial intervention, ...coordinates resident visits with outside services, dental, optical... Assists resident's families in coping with skilled nursing placement, physical illness and disabilities of the resident, and the grieving process..."

2. Medical record review for Resident #13 documented an admission date of 4/1/10 with diagnoses of Congestive Heart Failure, Hypothyroidism, Depression, Peripheral Vascular Disease, Dementia, Strokes and Failure to
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<tr>
<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<td><strong>F 250</strong></td>
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<td>Continued From page 4</td>
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<td>Facility Administrator will review the Social Services log of referrals for psycho-social needs and eyeglasses on a weekly basis for 3 months and follow-up to ensure all resident's needs are met in a timely manner.</td>
<td>7/15/10</td>
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<td>Thrive. Review of the &quot;Nutritional Progress Notes&quot; documented, &quot;4/7/10 Requested to see Dr [due to] poor intake. Res [Resident] does not want food. Hx [history] of anorexia per hosp [hospital] records. Reported not caring about eating. Remberone started in hospital for depression... Depression p [post] wife's death...5/4/10... Dialitian in room with resident to express concerns about his decreased p.o. [by mouth] intake and weight loss...6/2/10...spoken with family and they agree with the resident's decision for no tube feeding. They [resident and family] have also requested comfort measures only. Resident is refusing Magic cup at meals...&quot;</td>
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<td>Referrals for psycho-social needs and eyeglasses will be summarized and brought to the monthly Quality Assurance and Assessment (QA&amp;A) meeting by Social Services and reviewed in the meeting for 3 months.</td>
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<td>Review of the nurses' notes dated 6/9/10 documented, &quot;Resident awake moaning and fearful at [at] times...Resident extremely thin. Refuses to eat or take medications...&quot;</td>
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<td>The QA&amp;A Committee will determine the need for continued audit frequency at this time if 100% compliance has been met.</td>
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<td>Review of the &quot;Social Service Progress Notes&quot; dated 4/30/10 documented, &quot;This [named Resident #13], readmitted to this facility on 4/29/10...c [with] Dx [diagnosis]...Depression... Resident stated he is tired and would like to be left alone...5/3/10 Resident has adjusted well to this re-admit...Happy a room mate...&quot;</td>
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<td>Observations of Resident #13 in his bed 6/14/10 at 10:40 AM, revealed the resident with a frail thin appearance. His eyes were closed.</td>
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<td>During an interview outside Resident #13's room on 6/14/10 at 10:41 AM, Nurse #7 stated, &quot;...His wife had died and he has been so depressed. He refuses to eat, drink or take his medications...&quot;</td>
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<td>During an interview the conference room on 6/15/10 at 10:27 AM, the SW was asked by the</td>
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Continued From page 5

Surveyor: what was done by social services regarding Resident #13's depression and grieving. The SW stated, "It could be that he was just turned over to psych [psychiatric] services... I don't really know what was done unless I look through his chart..." The SW looked through Resident #13's chart and stated, "Yeah, here it is on 6/1/10 for psych services..." When the surveyor asked why it was not until 6/1/10 that psych services or something was done, because all other disciplines within the facility had documented about Resident #13's depression and weight loss. The SW stated, "I'll look in medical records to see if there is any more notes."

On 6/16/10 at 8:55 AM, Nurse #17 brought "Social Service Progress Notes" dated 6/2/10 and 6/8/10 into the conference room. The Social Service progress notes documented, "6/2/10 Resident continues to lose weight. Poor appetite noted. Depression. SS [social services] submitted psych referral per nursing. Resident requested to be left alone."

The SW failed to provide documentation that psychosocial support was provided to the resident and family members for the grieving process.

3. Medical record review for Resident #20 documented an admission date of 1/28/10 with diagnoses of Right Below Knee Amputation, Chronic Kidney Disease, Dialysis, Coronary Artery Disease, Morbid Obesity, Right Eye Surgically Removed and Hypertension. Review of the Minimum Data Set dated 4/18/10 documented Resident #20 had a modified independence in cognitive status and no problems with short-term memory.
Continued From page 6

Observations in Resident #20's room on 6/14/10 at 10:00 AM revealed Resident #20 lying in bed on his back with the head of his bed elevated 90 degrees watching television. Resident #20 was wearing a pair of eyeglasses that had tape around the left lens and frame and around the bottom of the right lens and frame. Resident #20 stated that his glasses had been broken for months. He further stated no one in the facility had worked with him to obtain a replacement for his glasses.

Observations in Resident #20's room on 6/15/10 at 7:33 AM, revealed Resident #20 was wearing the same glasses as observed on 6/14/20.

Observations in Resident #20's room on 6/16/10 at 10:14 AM, revealed Resident #20 had on a pair of glasses with the right lens missing and the frames were taped in several places.

During an interview in Resident #20's room on 6/16/10 at 10:14 AM, Resident #20 was asked about his glasses. Resident #20 stated, the glasses were broken about three to four months ago. Resident #20 stated he had an eye exam in April 2010 in this facility and was told his glasses would be ready in about a month.

Review of Social Services notes date 4/27/10 documented the glasses were ordered. The Social Services notes dated 6/16/10 at 10:05 AM documented the social worker was told this week Resident #20's glasses were broken.

During an interview in the Unit Manager’s office on 6/16/10 at 1:50 PM, the Social Worker confirmed she had talked with Resident #20’s son today and the glasses had not been ordered in April (2010).
Continued From page 7

and that he brought $100 to the facility to pay for them but it was given back to him. The Social Worker stated, "As of this afternoon new glasses have been ordered... and the son is willing to pay."

The SW failed to follow-up on Resident #20's glasses until the surveyors had brought it to her attention.

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review, and observation, it was determined the facility failed to provide appropriate treatment and services by allowing indwelling catheter tubing to lay on the floor and/or allowing the urinary drainage bag to be held above the bladder for 2 of 6 (Residents #8 and 14) sampled residents with indwelling catheters.

The findings included:

1. Review of the facility's catheter care policy documented "Catheter Care, Urinary...

CNAs were re-inserviced on the proper procedure for preventing the indwelling catheter tubing from touching the floor resident #14. Unit Manager assessed the urinary output for resident #14 and urine was noted to be clear amber, free of mucus or other particles and in adequate amounts. Resident #14 exhibited no sign of discomfort or distress.

On 8-17-10, Unit Managers identified residents with indwelling catheters and checked for the urinary drainage bag being held over the resident's bladder, and checked for the indwelling catheter tubing touching the floor. No residents were found with the urinary drainage bag being held over the resident's bladder, and no residents were found with the indwelling catheter tubing touching the floor.

Unit Managers re-inservice nursing staff on or before 7-14-10 on the proper procedure for preventing the urinary drainage bag from being held over the resident's bladder and the proper procedure for preventing the indwelling catheter tubing from touching the floor.
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<tr>
<th>ID</th>
<th>Provider's Plan of Correction</th>
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<tr>
<td>F 315</td>
<td>The Infection Prevention Nurse or designee will conduct weekly audits to ensure compliance with facility practice. Analysis of these audits will be brought to QA&amp;A Committee by the Infection Prevention Nurse. The findings of the audits will be brought to the monthly Quality Assurance and Assessment (QA&amp;A) meeting by the Infection Prevention Nurse or designee and reviewed for 3 months. The QA&amp;A Committee will determine the need for continued audit frequency at this time if 100% compliance has been met.</td>
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<td>F 318 SS-D</td>
<td>Resident #8 has orders in place to monitor the splint and condition of right palm. Care Plan and the Nurse’s Aide Information sheet have been updated to ensure implementation of changes. CNAs were re-inserviced on 6-16-10 regarding the proper placement and care of splint for resident #8.</td>
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**Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LSD identifying information):**

- **F 315**: Continued From page 8
  - Urinary drainage bag must be held or positioned lower than the bladder at all times...
  - Medical record review for Resident #8 documented an admission date of 12/1/07 with diagnoses of Failure to Thrive, Renal Medullary Necrosis, Pneumocystis, Anemia, and Foley catheter secondary to wounds.
  - Observations in Resident #8's room on 6/15/10 at 9:30 AM revealed Resident #8's indwelling catheter drainage bag and attached tubing was raised above the level of the bladder to the bed. The Certified Nursing Assistant (CNA #4) moved the bag from the side of the bed to the other.
  - Review of the facility's catheter care policy documented "Catheter Care, Urinary...11. Be sure the catheter tubing and drainage bag are kept off the floor."
  - Medical record review for Resident #14 documented an admission date of 11/20/06 with diagnoses of Depressive Disorder, Allergy, Anemia, Pneumocystis, Muscle Weakness, Pathologic Fracture Neck Femur, Dysphagia, Senile Dementia, and Congestive Heart Failure.
  - Observations in Resident #14's room on 6/14/10 at 2:25 PM and 6/15/10 at 7:35 AM revealed Resident #14's indwelling catheter tubing was touching the floor.

- **F 318 483.25(e)(2)**: Increase/Prevent Decrease in Range of Motion
  - Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives...
Continued From page 9
appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

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 hard splints did not cause skin discoloration for 1 of 6 (Resident #8) sampled residents observed with impaired range of motion.

The findings included:

Medical record review for Resident #8 documented an admission date of 12/1/07 with diagnoses of Failure to Thrive, Renal Medullary Necrosis, Pyelonephritis, Anemia and Foley catheter secondary to wounds.

Observations of a treatment and dressing change in Resident #8’s room on 6/15/10 at 9:45 AM, revealed Resident #8’s right palm area was dark brown in color.

During an interview in Resident #8’s room on 6/15/10 at 9:45 AM, the treatment nurse stated, “The splints from therapy caused this discoloration of skin to her hand...”

During an interview in the Director of Nursing’s (DON) office on 6/16/10 at 8:45 AM, the surveyor asked who was responsible for putting the splints on and checking for pressure or irritation from the splint. The DON stated, “CNA [Certified Nursing Assistant] tells nursing... Our restorative program...”

A facility audit was conducted by the Restorative Nurse on 6-29-10 to identify other residents with skin discoloration due to orthotic devices; no other residents were identified.

The Restorative Nurse will provide re-education for CNA & licensed staff on or before 7-14-10 to check for proper placement and do routine monitoring of skin for residents who have devices.

The Restorative Nurse or designee will conduct a weekly facility audit of residents identified with splints, braces or other devices to ensure proper placement and condition of resident’s skin.

The findings of the audits will be brought to the monthly Quality Assurance and Assessment (QA&A) meeting by the Restorative Nurse or designee and reviewed for 3 months.

The QA&A Committee will determine the need for continued audit frequency at this time if 100% compliance has been met.
**SPRING GATE REHAB & HEALTHCARE CENTER**

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<th>(X5) COMPLETION DATE</th>
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| F 318            | Continued From page 10  
|                  | is a work in progress. When I began there was no restorative program..." | F 318         |                                                                                                 |                     |
| F 322            | 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS  
| Ss-E             | Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastic or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-phenyngal ulcers and to restore, if possible, normal eating skills.  
|                  | This REQUIREMENT is not met as evidenced by:  
|                  | Based on policy review, medical record review, observations and interviews, it was determined the facility failed to ensure Nurse #2 checked the placement of a Percutaneous Endoscopic Gastrostomy (PEG) tube; flushed the PEG tube prior to administering medications and failed to administer medication per gravity for 1 of 2 Random Residents (RR #1). The facility failed to ensure proper care of a PEG tube was maintained when 1 of 6 Certified Nursing Assistants (CNA #4) turned a PEG tube pump off and 1 of 6 (CNA #6) CNAs failed to ensure a resident with a PEG tube was position appropriately as the feeding was infusing. The facility failed to ensure the PEG tube feeding was infusing or recorded for 5 of 9 (Residents #8, 10, 16, 18 and 27) sampled residents with PEG tubes.  
|                  | The findings included:  
|                  | 1. Review of the facility's "Administering..."                                                                                           |               |

*Certified Nursing Assistant (CNA) #4 was re-inservices on 6-22-10 by the Director of Nursing regarding notifying the nurse on duty to turn the feeding pump off. CNA #6 was re-inserviced on 6-22-10 by the Unit Manager regarding repositioning of resident while tube feeding is infusing.*

*Certified Nursing Assistant (CNA) #4 was re-inservices on 6-22-10 by the Director of Nursing regarding notifying the nurse on duty to turn the feeding pump off. CNA #6 was re-inserviced on 6-22-10 by the Unit Manager regarding repositioning of resident while tube feeding is infusing.*

*Certified Nursing Assistant (CNA) #4 was re-inservices on 6-22-10 by the Director of Nursing regarding notifying the nurse on duty to turn the feeding pump off. CNA #6 was re-inserviced on 6-22-10 by the Unit Manager regarding repositioning of resident while tube feeding is infusing.*

*A clarification physician's order was received for Resident #10 on 6-29-10 by the licensed nurse and reconciled with the Medication Administration Record (MAR) to reflect the correct order for the PEG tube feeding.*

*Nurses #10 and 5 were re-inserviced 6-18-10 by the Unit Manager to document in the medical record the formula and water intake for resident #15.*
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<td>F322</td>
<td>Continued From page 11</td>
<td>Medications through an Enteral Tube documented, &quot;...b. Auscultate the abdomen (approximately 3 inches below the sternalum) while injecting the air from the syringe into the tubing. a. Listen for 'whooshing' sound to check placement of the tube in the stomach ...&quot; Flush tubing with 15 to 30 ml [milliliters] warm water (or prescribed amount). Administer medication by gravity flow...&quot; Medical record review for RR #1 documented an admission date of 2/1/07 with diagnoses of Shaken Infant Syndrome, Severe Mental Retardation, Quadraplegia and Hypertension. Review of a physician's order dated 6/1/10 documented, &quot;...FLUSH FEEDING TUBE WITH 30CC [cubic centimeters] WATER BEFORE AND AFTER MEDICATIONS AND FEEDING ADMINISTRATION...&quot; Observations in RR #1's room on 6/14/10 at 4:35 PM, revealed Nurse #2 administered medications per PEG tube to RR #1. Nurse #2 failed to check the PEG tube placement per auscultation; failed to flush the PEG tube prior to administration of the medications and failed to administer medications per gravity. 2. Medical record review for Resident #8 documented an admission date of 12/1/07 with diagnoses of Failure To Thrive, Renal Medullary Necrosis, Pyelonephritis, Anemia and Foley catheter secondary to wounds. Observation in Resident #8's room on 6/15/10 at 9:45 AM, revealed CNA #4 turned the feeding pump off. During an interview in the conference room on</td>
<td>F322</td>
<td>Nurses #7 and 19 were re-inserviced on 6-22-10 by the Unit Manager to document in the medical record the formula and water intake for Residents #18 and 27. An audit was completed by the Unit Managers on 6-22-10 to identify other residents with PEG tubes which included: a. Nurses are checking tube placement per auscultation and providing a water flush as per doctor's orders before administering medications; b. Assessed to ensure CNAs have not turned off the feeding pump and that the residents are properly positioned in bed; c. Medical records were audited to ensure Physician's Orders are reconciled with the MAR to reflect the correct order; Medical records for residents with PEG tubes will be audited weekly to ensure nursing staff accurately document the amount of PEG tube feeding and water flushes. Unit Managers will re-inservce nursing staff on or before 7-14-10 regarding the proper procedure for checking PEG tube placement, flushing a PEG tube, administering medications via PEG tube, maintaining proper care of a PEG tube, accurate documentation of PEG tube feedings and flushes, proper positioning of residents in bed with PEG tube feeding is infusing and proper procedure for turning off the PEG tube feeding.</td>
<td>7/15/10</td>
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F 322  Continued From page 12

6/16/10 at 3:00 PM, the Director of Nursing (DON) stated, "We do not have a policy for the PEG or turning the pump off. The CNAs know to get the nurse to turn the [feeding] pump off...

3. Observations in Resident #8's room on 6/15/10 at 1:56 PM, CNA #6 positioned Resident #8's bed with the resident's head down and the resident's feet elevated. The feeding pump continued to infuse with the resident positioned with her head flat and her feet elevated.

During an interview in the conference room on 6/16/10 at 3:00 PM, the DON stated, "We do not have a policy for the PEG... The CNAs know to get the nurse to turn the pump off if they have to lie the resident's head down to provide care..."

4. Medical record review for Resident #10 documented an admission date of 2/1/07 and readmission date of 10/3/08 with diagnoses of Cerebral Thrombosis, Coronary Artery Disease, Gastrostomy, Diabetes, Hypertension, Fadible Convulsions, Dysphagia, Senile Dementia, Intracerebral Hemorrhage and Chronic Kidney Disease. Review of the Minimum Data Set (MDS) dated 3/3/10 documented the resident had short and long-term memory problems and was moderately impaired in decision making. She was assessed as total dependence with transfers, activities of daily living, and eating. Review of a physician's order dated 6/1/10 documented, "Nutren 2.0 at 85 ml (milliliters) / [per] hr [hour] x [times] 12 hours/day - on 4 PM, off 10 AM... Flush PEG tube w [with] 30ml water before and after medication administration, water flush with 200 ml every 6 hours... Document the amt [amount] of formula and water [water] provided every 24 hrs..." The current physician's order

F 322  ADNS and Unit Managers will conduct weekly audits on their assigned units to:

a. Observe nurses checking tube placement per auscultation and providing a water flush as per doctor's orders before administering medications;

b. Shift rounds to ensure that feeding pump have not been turned off inappropriately and that residents are properly positioned in bed.

Audits of medical records will be done by ADNS/Designee weekly to ensure Physician's Orders are reconciled with the MAR to reflect the correct order for the PEG tube feeding and accurate documentation the amount of PEG tube feeding and water flushes.

The findings of the audits will be brought to the monthly QA&A Committee meeting by the Director of Nursing or designee and reviewed for 3 months.

The QA&A Committee will determine the need for continued audit frequency at this time if 100% compliance has been met.
F 322 Continued From page 13
dated 6/1/10 was not reconciled to reflect the current PEG tube feeding on the Medication Administration Record (MAR).

Observation in Resident #10’s room on 6/16/10 at 7:45 AM, revealed no feeding was infusing as ordered.

5. Medical record review for Resident #15 documented an admission date of 3/17/10 and readmission date of 4/15/10 with diagnoses of Aphasia, Persistent Vegetative State, Intracranial Injury, Tracheotomy and Gastrostomy. Review of the MDS dated 3/23/10 documented the resident was in a persistent vegetative state. Review of a physician’s order dated 6/1/10 documented, “Diabetasource 65 ml/hr per PEG tube, flush tube with 30 cc water before and after medication administration, flush PEG with 180 cc’s water every 6 hours. There was no documentation in the medical record that the facility recorded the intake of the PEG tube feeding.

During an interview at nurse’s station 2 on 6/16/10 at 8:06 AM, Nurse #10 stated, “We don’t record PEG feeding intakes. The 11-7 nurse clears the pump. I don’t think they record that.”

During an interview at nurse’s station 2 on 6/16/10 at 8:07 AM, Nurse #5 stated, “If the doctor didn’t order for a total then they are not recording it.”

6. Medical record review for Resident #18 documented an admission date of 10/10/07 and a re-admission date of 2/8/10 with diagnoses of Dysphagia, History of Cerebrovascular Accident, Congestive Heart Failure, Peptic Ulcer Disease, Vascular Dementia, and Anemia. Review of a
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<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)</th>
<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>COMPLETION DATE</th>
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<td>F322</td>
<td>Continued From page 14</td>
<td>physician's orders dated 6/1/10 documented, &quot;...DIABETASOURCE 100 CC [cubic centimeter] X 16[HRS [hours]]... 300ML WATER FLUSH EVERY 8 HOURS... DOCUMENT THE AMOUNT OF FORMULA AND WATER PROVIDED EVERY 8 HOURS - TOTAL INTAKE EVERY 24 HRS...&quot; Review of the April and May 2010 MAR revealed there was no documentation of the amount of formula and water administered. During an interview at the Nurse Station 1 on 6/16/10 at 1:45 PM, Nurse #7 stated, &quot;...I don't record the amount. I don't go by the pump reading. I sign off on the MAR that the feeding was given, but not the amount.&quot;</td>
<td>F322</td>
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<td>Requirement</td>
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<td>Nurse #2 was re-inserviced by the Nursing Supervisor on 6-19-10 to provide water flushes per doctor's orders and re-check MARs to confirm the proper dose prior to administering medications to Random Resident #1.</td>
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<td>Nurses #2, 3, 8 and 10 were re-inserviced by the Unit Manager on 6-22-10 regarding the proper procedure for immediately providing a protein snack after administering Novolog insulin to Resident #28, Resident #13, Random Resident #14 and Resident #18.</td>
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<td>An audit was conducted by the Unit Manager on 6-30-10 to identify other residents receiving Novolog insulin.</td>
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<td>Residents receiving Novolog insulin were reviewed by the Unit Managers on 6-30-10 to ensure nurses immediately provide a protein snack after administering Novolog insulin.</td>
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<td>Re-training for licensed nurses will be completed by Unit Managers on or before 7-14-10 regarding the proper procedure for flushing a PEG tube prior to administering medications via PEG tube.</td>
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<td>Licensed nurses will complete a med pass competency under the observation of the SDC or designee on hire and at least annually.</td>
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<td>ADNS and Unit Managers will conduct audits weekly on their assigned units of residents receiving Novolog insulin to ensure that nurses immediately provide a protein snack after administering Novolog insulin.</td>
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| F 332            | Continued From page 16
Diltiazem 60mg Tablet take 1 tab per tube three times daily... Buspirone HCL [hydrochloride] take 2 tabs (20mg) per tube three times daily...
Observations in RR #1's room on 8/14/10 at 4:35 PM, revealed Nurse #2 administered medications per Percutaneous Endoscopic Gastrostomy (PEG) tube to RR #1. Nurse #2 did not flush the PEG tube prior to administration of the medications. The failure to flush the PEG tube resulted in medication error #1. Nurse #2 administered Topiminate 25mg to RR #1 instead of 75mg which resulted in medication error #2.

2. Review of the "MED-PASS COMMON INSULINS: Pharmacokinetics, Compatibility, and Properties" provided by the American Society of Consultant Pharmacists for typical dosing administration of insulin related to meals documented, "Novolog... Onset (in hours, unless noted) 16 min [minutes]... Typical dosing / Comments... 5-10 minutes before meals..."

a. Medical record review for Resident #28 documented an admission date of 2/1/07 with a readmission date of 4/30/09 with diagnoses of Diabetes, Coronary Artery Disease, Muscle Weakness, Hemiplegia and Esophagitis. Review of a physician's order dated 9/1/10 documented, "Novolog 100 U [unit]/[per] 1ml Unit Inject Sub-Q [subcutaneous] Per Sliding Scale 301-400 = [amount of insulin to be administered] 8 Units..."

Observations in Resident #28's room on 6/15/10 at 11:10 AM, revealed Nurse #10 administered 8 units of Novolog insulin to Resident #28. Resident
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<td>#28 did not receive her lunch tray until 12:20 PM. The administration of the insulin 1 hour and 10 minutes before lunch was served resulted in medication error #3.</td>
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<td>During an interview on the 200 hall on 6/16/10 at 9:44 AM, Nurse #10 stated, &quot;They just told us to give the insulin with a snack.&quot;</td>
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<td>b. Medical record review for RR #13 documented an admission date of 9/25/09 with diagnoses of Diabetes Mellitus, Cardiac Dysrhythmias, Hypertension, Peripheral Vascular Disease and Depressive Disorder. Review of a physician's order dated 6/1/10 documented, &quot;NOVOLOG 100 U/1ML UNIT INJECT SUB-Q PER SLIDING SCALE...201-250 =4 UNITS...&quot;</td>
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<td>Observations in RR #13's room on 6/14/10 at 4:35 PM, revealed Nurse #3 administered Novolog 4 units to RR #13. RR #13 did not receive his supper until 5:35 PM. The administration of the insulin one hour before supper was served resulted in medication error #4.</td>
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<td>During an interview on the 100 Hall on 6/16/10 at 9:30 AM, Nurse #3 stated, &quot;He [RR #13] was going to supper after I gave him the insulin.&quot;</td>
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<td>c. Medical record review for RR #14 documented an admission date of 12/19/06 with a readmission date of 1/22/08 with diagnoses of Diabetes Mellitus, Congestive Heart Failure, Depressive Disorder, Senile Dementia with Depressive Features and Hypertension. Review of a physician's order dated 6/1/10 documented, &quot;NOVOLOG 100 U/1ML UNIT INJECT SUB-Q PER SLIDING SCALE 200-300 = 4 UNITS...&quot;</td>
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**F 332** Continued From page 18

Observations in RR #14's room on 6/15/10 at 5:00 PM, revealed Nurse #10 administered Novolog 4 units to RR #14. At 6:05 PM, RR #14 had not received her supper tray. The administration of the insulin one hour before supper was served resulted in medication error #5.

d. Medical record review for RR #18 documented an admission date of 2/1/07 with diagnoses of Amputation Above Knee, Diabetes Mellitus, Osteoporosis and Hyperlipidemia. Review of a physician's order dated 6/1/10 documented, "NOVOLOG 100U /1ML UNIT INJECT SUB-Q PER SS [sided scale]: 200-300=4 UNITS..."

Observations in RR #18's room on 6/15/10 at 11:22 AM, revealed Nurse #8 administered Novolog 4 units to RR #18. RR #18 did not receive his lunch tray until 12:23 PM. The administration of the insulin more than an hour before RR #18 received his lunch meal resulted in medication error #6.

During an interview on the 200 hall on 6/15/10 at 9:20 AM, Nurse #8 stated, "I should have waited before giving the insulin. The time is an issue."

**F 333**

The facility must ensure that residents are free of any significant medication errors.

Nurses #3, 8 and 10 were re-instructed by the Unit Manager on 6-22-10 on the proper procedure for immediately providing a protein snack after administering Novolog Insulin to Resident #28, Random Resident #13, 14 and 18.

All residents receiving Novolog insulin were reviewed to ensure nurses immediately provide a protein snack after administering insulin.
Consultant Pharmacist, medical record review, observations and interviews, it was determined the facility failed to ensure that residents were free of significant medication errors when 3 of 15 nurses (Nursetta 3, 8 and 10) observed during medication administration time was confirmed on or before 7-14-10 on Insulin administration and peak times as well as the need for a protein snack.

The findings included:

1. Review of the "MED-PASS COMMON INSULINS: Pharmacokinetics, Compatibility, and Properties" provided by the American Society of Consultant Pharmacist for typical dosing administration of insulin related to meals documented, "Novolog... ONSET (in hours, unless noted)... 15 min [minutes]... TYPICAL DOZING / COMMENTS... 5-10 minutes before meals..."

2. Medical record review for Resident #28 documented an admission date of 2/1/07 with a readmission date of 4/30/09 with diagnoses of Diabetes, Coronary Artery Disease, Muscle Weakness, Hemiplegia and Esophagitis. Review of a physician's order dated 6/1/10 documented, "NOVOLOG 100 U [unit] [per] 1 mL UNIT INJECT SUB-Q [subcutaneous] PER SLIDING SCALE 301-400 = [amount of insulin to be administered] 8 UNITS..."

Observations in Resident #28's room on 6/15/10 at 11:10 AM, revealed Nurse #10 administered 8 units of Novolog insulin to Resident #28. Resident #28 did not receive her lunch tray until 12:20 PM. The administration of the insulin 1 hour and 10 minutes before lunch was served resulted in a significant medication error.
**SPRING GATE REHAB & HEALTHCARE CENTER**

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| F 333         | Continued From page 20  
During an interview on the 200 hall on 6/16/10 at 9:44 AM, Nurse #10 stated, "They just told us to give the insulin with a snack."  
3. Medical record review for Random Resident (RR) #13 documented an admission date of 9/25/08 with diagnoses of Diabetes Mellitus, Cardiac Dysrhythmias, Hypertension, Peripheral Vascular Disease and Depressive Disorder. Review of a physician's order dated 6/1/10 documented, "NOVOLOG 100 U/ML UNIT INJECT SUB-Q PER SLIDING SCALE .201-250 =4 UNITS..."  
Observations in RR #13's room on 6/14/10 at 4:35 PM, revealed Nurse #3 administered Novolog 4 units to RR #13. RR #13 did not receive his supper until 5:35 PM. The administration of the insulin one hour before supper was served resulted in a significant medication error.  
During an interview on the 100 Hall on 6/16/10 at 9:30 AM, Nurse #3 stated, "He [RR #13] was going to supper after I gave him the insulin."  
4. Medical record review for RR #14 documented an admission date of 12/13/08 with a readmission date of 1/22/08 with diagnoses of Diabetes Mellitus, Congestive Heart Failure, Depressive Disorder, Senile Dementia with Depressive Features and Hypertension. Review of a physician's order dated 6/1/10 documented, "NOVOLOG 100 U/ML UNIT INJECT SUB-Q PER SLIDING SCALE 200-300 = 4 UNITS..."  
Observations in RR #14's room on 6/15/10 at 5:00 PM, revealed Nurse #10 administered Novolog 4 units to RR #14. At 6:05 PM, RR #14 | F 333         |
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<td>F 431</td>
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### F 333
Continued From page 21
had not received her supper tray. The administration of the insulin one hour before supper was served in a significant medication error.

6. Medical record review for RR #18 documented an admission date of 2/1/07 with diagnoses of Amputation Above Knee, Diabetes Mellitus, Osteoporosis and Hyperlipidemia. Review of a physician's order dated 6/1/10 documented, "NOVOLOG 100U/1ML UNIT INJECT SUB-Q PER SS [sliding scale]: 200-300=4 UNITS..."

Observations in RR #18's room on 6/15/10 at 11:22 AM, revealed Nurse #8 administered Novolog 4 units to RR #18. RR #18 did not receive his lunch tray until 12:23 PM. The administration of the insulin more than an hour before RR #18 received his lunch meal resulted in a significant medication error.

During an interview on the 200 hall on 6/15/10 at 9:20 AM, Nurse #8 stated, "I should have waited before giving the insulin. The time is an issue." 483.80(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the
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F 431 Continued From page 23
and trays or carts to transport such items shall not be left unattended if open or otherwise potentially available top others...

Observations in hall 4 on 8/14/10 at 4:30 PM, revealed a cup with two pills was left unattended on top of hall 4 medication cart.

Observations in hall 4 on 6/15/10 at 8:28 AM, revealed the hall 4 medication cart was left unattended, unlocked, and out of view of the nurse.

During an interview on the 400 hall on 8/16/10 at 9:30 AM, Nurse #1 stated, "I was nervous. I know it's [medication cart] suppose to be locked."

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

CNAs #1, 3, 4 were re-educated on the facility's procedure for hand hygiene.
Nurses #2, 8, and 7 were re-educated on the facility's procedure for hand hygiene.
Nurse #15 was re-educated on the proper procedure for wound cleansing.
Nurses #3 and 5 were re-educated on the proper procedure for cleaning the glucometer machine with Sanit-Cloth bleach wipes.
Residents will continue to be monitored for signs and symptoms of infection and treated as indicated.

All nursing staff will be re-inserviced by SDC or designee on or before 7-14-10 on the proper procedure for hand hygiene.
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<td>F 441</td>
<td>Continued From page 24 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 resident contact for which hand washing is indicated by accepted professional practice. (c) 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 reviews, observations, and interview, it was determined 6 of 21 nurses (Nurse #3, 5, 7, 8, 15 and 21) and 3 of 6 Certified Nursing Assistants (CNA #1, 3 and 4) failed to properly wash hands; turn the faucet off with a paper towel; properly clean a wound; or clean a glucometer with Sani-Cloth Bleach wipes in a manner to prevent the potential spread of infections. The findings included: 1. Review of the facility's &quot;Handwashing/Hand Hygiene&quot; policy documented, &quot;...This facility considers handwashing/hand hygienes as the primary means to prevent the spread of infections...&quot; Review of the facility's &quot;Hand Hygiene/Washing Clinical Performance Evaluation Checklist&quot;</td>
<td>F 441</td>
<td>All licensed nurses will be re-inserviced by SDC or designee on or before 7-14-10 on the procedure for cleaning the glucometer machine between residents. All licensed nurses will be re-inserviced by SDC or designee on or before 7-14-10 on the proper wound cleaning procedure. Infection Prevention Nurse will conduct weekly infection prevention rounds. The findings of the audits will be brought to the monthly QA&amp;A Committee meeting by the Infection Prevention Nurse or designee and reviewed for 3 months. The QA&amp;A Committee will determine the need for continued audit frequency at this time if 100% compliance has been met.</td>
<td>7/15/10</td>
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F 441 Continued From page 26...Applied skin cleanser or soap to hands...Dried hands on paper towel, Turned off facet with paper towel, Discard towel...

2. Observations in the 500 half dining room on 6/15/10 at 7:30 AM, revealed CNA #1 served a meal tray and proceeded to wash her hands without using soap and turned the faucet off with her bare hand.

3. Observations in the 500 half dining room on 6/15/10 at 7:35 AM, revealed CNA #3 served a meal tray, then washed her hands and turned the faucet off with her bare hand.

Observations in room 128 on 6/16/10 at 8:35 AM revealed CNA #3 brought a breakfast tray into room 128, removed a mat from the floor, repositioned the resident in bed and then peeled 2 boiled eggs with her bare hands. CNA #3 did not wash her hands after direct contact with items on the floor, after direct contact with the resident, or before leaving the room. CNA #3 did not wear gloves while handling the food.

4. Observations in the magnolia dining on 6/15/10 at 11:42 AM, revealed Nurse #21 touched a resident's chair, patted the resident on the arm, applied the clothes protector, and went to the tray cart to remove the resident's tray without washing his hands.

5. Observations on the 200 half on 6/15/10 at 11:22 AM, during medication pass administration revealed Nurse #8 washed her hands and then turned the faucet off with her bare hand.

6. Observations in Random Resident (RR) #17 room on 6/15/10 at 9:20 AM, revealed Nurse #7
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES**  
**AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLA**  
**IDENTIFICATION NUMBER:** 445220

**(X2) MULTIPLE CONSTRUCTION**  
**A. BUILDING**  
**B. WING**

**(X3) DATE SURVEY COMPLETED:** 08/16/2010

**NAME OF PROVIDER OR SUPPLIER:**  
**SPRING GATE REHAB & HEALTHCARE CENTER**

**STREET ADDRESS, CITY, STATE, ZIP CODE:**  
**3909 COVINGTON PIKE**  
**MEMPHIS, TN 38135**

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<td>washed her hands and and turned the faucet with her bare hands.</td>
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<td>7. Review of the Facility's &quot;Dressings, Dry/Clean policy documented..., if using gauze, use clean gauze for each cleansing stroke. Clean from the least contaminated area to the most.,&quot;</td>
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<td>Observations during a dressing change in Resident #8's room on 6/15/10 at 9:30 AM, Nurse #15 did wound care for Resident #8's right sacrum. The stage 4 right sacrum wound measured 2.7 centimeter (cm) long, 2.7 cm wide, 0.4 cm deep. Nurse #15 wiped the contaminated wound area in a clock-wise circle twice with the same gauze.</td>
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<td>8. Observations in Resident #8's room on 6/15/10 at 9:50 AM, during the wound dressing change revealed CNA #4 removed a soiled diaper and did not wash her hands after removing her gloves.</td>
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<td>Observations in Resident #8's room on 6/15/10 at 9:51 AM, CNA #4 donned gloves, performed peri-care, removed the gloves but did not wash her hands after removing her gloves.</td>
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<td>9. Observations on the 300 Hall on 6/14/10 at 4:36 PM, revealed Nurse #3 did not clean the glucometer machine before or after she checked RR #13's blood sugar.</td>
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<td>10. Observations on the 100 hall on 6/16/10 at 6:50 PM, revealed Nurse #6 cleaned the glucometer machine with an alcohol swab before and after an accucheck on RR #15. Nurse #6 did not use the Sani-Cloth Blesch wipes.</td>
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11. During an interview in the Director of Nurse's (DON) office on 6/16/10 at 1:25 PM, the DON confirmed that the glucometer machines should be cleansed with Sani-Cloth Bleach wipes.

483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS

The facility must equip corridors with firmly secured handrails on each side.

This REQUIREMENT is not met as evidenced by:

Based on observation and interview, it was determined the facility failed to ensure handrails were securely fastened to the walls on 2 of 5 (Hall 2 and Hall 4) halls.

The findings included:

1. Observations on Hall 2 on 6/16/10 at 8:25 AM, revealed the handrail located between Room 238 and Room 240 was not securely fastened to the wall and would shake when touched.

Observations on Hall 2 on 6/15/10 at 12:16 PM, revealed the handrail to the left side of Room 204 was not securely fastened to the wall and would shake when touched.

2. Observation on Hall 4 on 6/19/10 at 10:45 AM, revealed the handrail to the right side of Room 430 was not securely fastened to the wall and would shake when touched.

During an interview at the Station 4 Nurses Station on 6/16/10 at 11:00 AM, the Maintenance Supervisor stated, "They fill out maintenance requests and leave at their nurses station. Then I..."
**SPRING GATE REHAB & HEALTHCARE CENTER**

F 468 Continued From page 28

periodically pick them up to do repairs." The Maintenance Supervisor was asked if there was a process for repairing or checking the handrails. The Maintenance Supervisor "No we do not."

F 469 483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM

The facility must maintain an effective pest control program so that the facility is free of pests and rodents.

This REQUIREMENT is not met as evidenced by:

Based on observations and interviews, it was determined the facility failed to have an effective pest control program as evidence of the presence of flies in 13 of 124 (rooms 104, 119, 122, 126, 132, 223, 323, 417, 427, 429, 431, 433 and 436) resident rooms; 3 of 6 (100, 200 and 300 halls) halls; the laundry area hallway; 600 hall dining room and the main dining room.

The findings included:

1. Observations in resident room 104 on 6/14/10 at 10:02 AM, revealed three flies on Resident #7 (one on his arm and 2 on his chest).

   During an interview in room 104 on 6/14/10 at 10:02 AM, Random Resident (RR) #24 stated, "These flies will drive you crazy."

   Observations in room 104 on 6/15/10 at 2:03 PM, revealed flies swarming around and on Resident #7's upper body.

   Observations in resident room 104 on 6/15/10 at

**Pest contractor consulted with Maintenance Director and Administrator on placement of insect equipment on 6-21-10.**

**8 Insect lamps were purchased from vendor.**

**New fly fan was purchased and installed for the rear exit.**

**Rooms 104, 119, 122, 126, 132, 223, 431, 433, and 436 were cleaned by housekeeping on 06/25/2010 and 6/28/10.**

**Housekeeping Supervisor to monitor rooms on a weekly basis using The Housekeeping Quality Control Inspection Tool.**

**Administrator to monitor during weekly rounds using the Housekeeping Quality Control Checklist.**

**Housekeeping Supervisor or designee to report his findings on a monthly basis to the OA&A Committee for 3 months.**

**The OA&A Committee will determine the need for continued audit frequency at this time if 100% compliance has been met.**
<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X5) ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X6) COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 469</td>
<td>Continued From page 29 5:40 PM and on 6/16/10 at 9:05 AM, revealed the presence of flies.</td>
<td>F 469</td>
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<td>2. Observations in room 119 on 6/14/10 at 9:35 AM, revealed a fly on Resident #27's chest.</td>
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<td>3. Observations in room 122 on 6/15/10 at 5:20 PM, revealed the presence of flies.</td>
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<td>4. Observations in resident room 128 on 6/16/10 at 9:00 AM, revealed a fly on Resident #21's pillow and breakfast tray.</td>
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<td>5. Observations in room 132 on 6/14/10 at 10:30 AM, revealed the presence of a fly.</td>
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<td>6. Observations in room 223 on 6/14/10 at 4:55 PM, revealed the presence of flies.</td>
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<td>7. Observations in room 323 on 6/14/10 at 9:40 AM, revealed the presence of flies.</td>
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<td>8. Observations in room 417 on 6/14/10 at 4:17 PM and 4:35 PM, revealed the presence of flies.</td>
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<td>10. Observations in room 429 on 6/14/10 at 9:45 AM, revealed the presence of flies.</td>
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<td>11. Observations in room 431 on 6/14/10 at 9:35 AM, revealed the presence of flies.</td>
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<td>12. Observations in room 433 on 6/14/10 at 9:40 AM, revealed the presence of a fly.</td>
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<td>13. Observations in room 438 on 6/15/10 at 5:40 AM, revealed the presence of a fly.</td>
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| F 469         | Continued From page 30 PM, revealed the presence of flies.  
14. Observations in the 100 hall on 6/15/10 at 7:45 AM and 12:20 PM, revealed the presence of flies.  
16. Observations in the 200 hall on 6/14/10 at 5:15 PM, revealed the presence of flies.  
Observations in the 200 hall on 6/15/10 at 11:06 AM, revealed Nurse #9 walking down the hall with a fly swatter under her arm.  
16. Observations in the 300 hall on 6/14/10 at 3:30 PM, revealed the presence of flies.  
17. Observations in the laundry area hallway on 6/14/10 at 1:55 PM, revealed the presence of a fly.  
18. Observations in the 500 hall dining room on 6/14/10 at 5:25 PM, on 6/16/10 at 7:30 AM and 10:22 AM, and on 6/16/10 at 7:35 AM, revealed the presence of flies.  
19. Observations in the main dining room on 6/15/10 at 11:45 AM, revealed RR #26 swatted at a fly with a fly swatter.  
During an interview in the main dining room on 6/16/10 at 11:46 AM, RR #26 stated, "There was a fly but it flew away before I got him."
Observations in the main dining room on 6/15/10 at 12:05 PM, RR #25 walked into the main dining room with a fly swatter.  
During an interview in the main dining room on 8/16/10 at 12:05 PM, RR #25 stated, "They gave
**SPRING GATE REHAB & HEALTHCARE CENTER**

**F 469**
Continued From page 31
me this (fly swatter) so if I see one (fly), I can mudder it."

During an interview in the main dining room on 6/15/10 at 12:12 PM, the Dietary Manager stated, "I know that maintenance has been hanging things on the wall... It got so hot so fast, I think they (flies) just want to get in."

During an interview in the main dining room on 6/16/10 at 1:50 PM, the Administrator stated, "Pest control was here last Thursday [6/10/10]." Pest Control Policy with attached company will provide such services as needed to effectively control... (with the exception of flies...)."

**F 514**
483.75(1)(1) RES
RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, it was determined the facility failed to maintain medical records that were complete and accurate by not reconciling physician's orders.

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<td>F 514</td>
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<td>The diet order for Resident #14 has been clarified and resident is to continue receiving a pureed diet with honey thick liquids. Resident was assessed for adverse reactions and none noted.</td>
<td>7/15/10</td>
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**F 514** Continued From page 32 and failure to document administration of medications as ordered by the physician for 3 of 28 (Resident #14, 17 and 21) sampled residents

The findings included:

1. Medical record review for Resident #14 documented an admission date of 11/20/09 with diagnoses of Depressive Disorder, Allergy, Arthropyathy, Anemia, Peptic Ulcer Disease, Mucous Weakness, Dysphagia, Senile Dementia, and Congestive Heart Failure (CHF). Review of a telephone order dated 4/30/10 documented "...diet consistency [symbol for change] to puree solids [with] honey thickened liquids..." Review of the physician's orders for the time period of 5/1/10 through 5/31/10 and 6/1/10 through 6/30/10 documented "...DIET ORDERS... MECH [mechanical] SOFT DIET... HOUSE SUPPLEMENT 120 ML [milliliters]...NECTAR THICK CONSISTENCY... PRUNE JUICE (NECTAR THICK) 120 ML... TWICE A DAY..."

Observation in Resident #14's room on 6/15/10 at 8:25 AM, revealed Resident #14 was served a Puree diet with honey thick liquids.

During an interview at the Station Two Nurses Station on 6/15/10 at 1:30 PM, Nurse #18 stated when reconciling the physician's orders, "the nurses review the previous orders and update the orders based on this, they should look at last two months of orders, that is our protocol." Nurse #18 confirmed the physician diet orders were not reconciled correctly.

2. Medical record review for Resident #17 documented an admission date of 8/4/08 and a readmission date of 1/1/10 with diagnoses of

Resident's who had current orders for diet changes were reviewed on 6-18-10 by the Interdisciplinary team. The orders were reviewed and confirmed to have been carried out and documented properly.

Orders for diet changes will be audited weekly in the Interdisciplinary team meeting.

Licensed nurses will be re-instructed by SDC or designee on or before 7-14-10 on the proper procedure for carrying out orders for diet changes, documentation of medication administration and reconciling the monthly Physician's Orders Sheets.

The findings of the audits will be brought to the monthly QA&A Committee meeting by the Director of Nursing or designee and reviewed for 3 months.

The QA&A Committee will determine the need for continued audit frequency at this time if 100% compliance has been met.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

Provider/Supplician Identification Number: 445220

**NAME OF PROVIDER OR SUPPLIER:**
SPRING GATE REHAB & HEALTHCARE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
3908 COVINGTON PIKE
MEMPHIS, TN 38125

**DATE SURVEY COMPLETED:**
06/16/2010

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<td><strong>Transient Cerebral Ischemia, Hypertension, Osteoarthritis, Arthropathy, Peripheral Vascular Disease, Cerebrovascular Disease, Hemiplegia, Hypertonicity of Bladder, Acute Renal Failure, Depression, Dementia, and Muscle Weaknesses.</strong> Review of a telephone order dated 5/31/10 documented &quot;...TF [tube feeding] to Nutren 2.0 5 cans/day per peg [Percutaneous Endoscopic Gastrostomy] tube...&quot; Review of the physician's orders dated 6/1/10 documented &quot;...2 Cal [calorie]... 240 ml [milliliters] q [every] 4 o [hours] per peg.&quot; Review of the Medication Administration Record dated 6/1/10 documented &quot;...nutren 2.0 5 cans/day...&quot; The June 10'10 MAR did not include the order for 2 Cal q 4 hours per peg. During an interview on the 200 hall on 6/14/10 at 3:55 PM, Nurse #20 stated &quot;He [Resident #17] is getting Nutren five cans every day&quot;. 3. Medical record review for Resident #21 documented an admission date of 6/10/10 with diagnoses of Dementia, Diabetes Type II, Anxiety, Restless Leg Syndrome, Gastroesophageal Reflux Disease, and Chronic Pancreatitis. Review of a physician's order dated 6/14/10 documented &quot;...omeprazole 40mg [milligrams] cap [capsule] PO [by mouth] Q [every] day...&quot; The &quot;Admission Orders - Administration Record&quot; had no documentation that Omeprazole had been administered to Resident #21 as ordered. During an interview on the 100 hall on 6/16/10 at 9:00 AM, Nurse #7 was asked if Resident #21 had received Omeprazole as ordered. Nurse #7 looked at the medication administration record and stated, &quot;It was ordered 2 days ago...can't tell if she [Resident #21] got the pills. The nurse...&quot;</td>
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**FORM CMSS-25597(02-99) Previous Versions Omitted**

Event ID: WM2011
Facility ID: TN1624
If continuation sheet Page 3 of 35
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<td>Continued From page 34 didn't document it [that Omeprazole was administered].</td>
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NAME OF PROVIDER OR SUPPLIER: SPRING GATE REHAB & HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 3000 COVINGTON PIKE, MEMPHIS, TN 38135

DATE SURVEY COMPLETED: 06/16/2010