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

<table>
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<tr>
<th><strong>STATEMENT OF DEFICIENCIES</strong></th>
<th><strong>(X1) PROVIDER/SUPPLIER/CLA</strong></th>
<th><strong>(X2) MULTIPLE CONSTRUCTION</strong></th>
<th><strong>(X3) DATE SURVEY</strong></th>
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<tr>
<td><strong>AND PLAN OF CORRECTION</strong></td>
<td><strong>IDENTIFICATION NUMBER:</strong></td>
<td><strong>A. BUILDING:</strong></td>
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<td>445139</td>
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**NAME OF PROVIDER OR SUPPLIER**  
**SIGNATURE HEALTHCARE AT ST PETER VILLA**  
**STREET ADDRESS, CITY, STATE, ZIP CODE**  
141 N MCLEAN  
MEMPHIS, TN 38104

<table>
<thead>
<tr>
<th><strong>(X4) ID</strong></th>
<th><strong>(X5) ID</strong></th>
<th><strong>SUMMARY STATEMENT OF DEFICIENCIES</strong></th>
<th><strong>F 272</strong></th>
<th><strong>(X6) DATE</strong></th>
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<tr>
<td><strong>PREFIX</strong></td>
<td><strong>TAG</strong></td>
<td><strong>(EACH DEFICIENCY MUST BE PRECEDED BY FULL</strong></td>
<td><strong>483.20(b)(1) COMPREHENSIVE</strong></td>
<td><strong>F 272</strong></td>
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<td><strong>TAG</strong></td>
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<td><strong>REGULATORY OR LSC IDENTIFYING INFORMATION)</strong></td>
<td><strong>ASSESSMENTS</strong></td>
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The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin-conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.

Signature Healthcare at St. Peter Villa will continue to conduct initial and periodic comprehensive, accurate, standardized reproducible assessments of each resident's functional capability including a comprehensive assessment of a resident's needs using the resident assessment instrument specified by the State. Signature Healthcare at St. Peter Villa will continue to properly assess and identify skin breakdown prior to the development of an unstageable pressure ulcer.

**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE**  
Pamela J. Gomes RN  
**TITLE**  
Administrator  
4/12/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 60 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
### F 272 - Continued From page 1

This **REQUIREMENT** is not met as evidenced by:

Based on review of the "National Pressure Advisory Panel [NPUAP] Pressure Ulcer Prevention QUICK REFERENCE GUIDE", policy review, medical record review, observation and interview, it was determined the facility failed to properly assess residents for pressure ulcers or vision for 2 of 16 (Residents #5 and 189) sampled residents reviewed of the 40 residents included in the Stage 2 review. The facility's failure to properly assess and identify skin breakdown prior to the development of an unstable pressure ulcer resulted in actual harm to Resident #5.

The findings included:

1. Review of the "National Pressure Advisory Panel Pressure Ulcer Prevention QUICK REFERENCE GUIDE" documented, "...9... Unstable/Unclassified: Full thickness skin or tissue loss-depth unknown Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown, or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV... 12... 3. Inspect skin regularly for signs of redness... Ongoing assessment of the skin is necessary to detect early signs of pressure damage. 4. Skin inspection should include assessment for localized heat, edema, or induration (hardness), especially in individuals

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<tr>
<td>F 272</td>
<td>Immediate Interventions: 1. 100% skin audits on all residents completed by licensed nursing by 3/29/12 with results reported to DON and administrator.</td>
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<td>2. MDS Coordinators audited 100% all MDS/Care Plans for accuracy and appropriate interventions including residents #5 and #189 by 3/30/12.</td>
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<td>3. 100% audits of all resident's wounds for appropriate treatments and intervention and care plans updated as needed wound care nurse 3/30/12 with results to DON and administrator.</td>
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<td>Identification of the residents with potential to be affected: 4. 100% skin audits completed on all residents 3/29/12, then weekly for four weeks, monthly and pm by nursing management or designee with results to DON and administerator immediately, variances corrected, staff re-educated immediately, in orientation, monthly, and pm with variance reported to QA.</td>
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<td>Measures to prevent recurrence: 5. 100% all nursing staff in-serviced on wound prevention, assessment, intervention interaction, treatment, and documentation procedures in orientation, monthly, and pm by 4/12/12.</td>
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<td>6. Skin audit sheets and wound treatment records to be reviewed by DON, nurse manager or designee weekly and pm initiated 4/6/12 with variances corrected and staff in-serviced by staff development coordinator/designee.</td>
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<tr>
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<td>7. All wounds will continue to be reviewed daily in clinical meeting and during risk management meeting weekly for treatment effectiveness, interventions, and progression by the DON, wound care nurse, certified dietary manager, and nursing management effective 3/28/12.</td>
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<tr>
<td>F 272</td>
<td>Continued From page 2 with darkly pigmented skin...</td>
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<td>Review of the facility's &quot;Skin Care Protocol&quot; policy documented, &quot;...New skin breakdown A. Treatment nurse, nurse manager, M.D. [Medical Doctor], and D.O.N. [Director of Nursing], notified of new breakdown B. Treatment nurse examines, writes, and initiates orders...&quot;</td>
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<td>Medical record review for Resident #5 documented an admission date of 12/1/10 with diagnoses of Coronary Artery Disease, Adult Failure to Thrive, Hypertension, Dementia, Congestive Heart Failure, Schizophrenia, Deafness and Blindness. Review of a &quot;C.N.A. [Certified Nursing Assistant] SKIN CARE ALERT&quot; form dated 2/18/12 documented a lesion to Resident #5's right foot. Review of a &quot;DAILY SKILLED NURSE'S NOTE&quot; dated 2/19/12 documented, &quot;...Skin WNL [within normal limits] [check mark]...&quot; Review of a &quot;DAILY SKILLED NURSE'S NOTE&quot; dated 2/20/12 documented, &quot;...Skin WNL [within normal limits] [check mark]...&quot; and a written narrative of &quot;...Resident noted with area of eschar plantar aspect. New order received for Betadine daily...&quot;</td>
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|       | Review of an "INDIVIDUAL SKIN REPORT" dated 2/20/12 documented, ".DATE OF ONSET: 2-20-12 R [Right] plantar... Facility Acquired: [check mark]... [check mark] Pressure... [check mark] Unstageable Pressure Ulcers due to sloughing and/or eschar... Measurements (cm) [centimeters], L [length] 2.0 W [width] 2.0 D [diameter] U [unstable]... Type Wound PU [pressure ulcer] Stage U [unstageable]...
<p>| F 272 | Monitoring: 8. DON or designee to audit weekly five residents for potential skin issues with immediate in-service for variances found, report findings to administrator immediately and QA monthly for input and recommendations effective 4/12/12. 9. All skin issues continue to be discussed daily in clinical meeting by Interdisciplinary Team for appropriateness, interventions, and treatment with results to administrator immediately and QA monthly for input and recommendations effective 3/28/12. 10. DON or designee to perform wound rounds with treatment nurse weekly for four weeks then monthly on three residents to ensure appropriate treatment staging, interventions including positioning devices in use with all variances corrected, staff in-service with variance reported to administrator immediately and QA monthly for input and recommendations effective 4/12/12. |</p>
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<th>F 272</th>
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<td>the following:</td>
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<td>a. 2/15/12 &quot;...Skin Condition: clear...&quot;</td>
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<td></td>
<td>b. 2/20/12 &quot;...Skin Condition: Rt [right] foot Ball of foot below great toe...&quot;</td>
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<td></td>
<td>c. 2/22/12 &quot;Skin Condition; Good... Necrosis R [right] gt [great] toe unchanged...&quot;</td>
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<td>Review of the &quot;TREATMENT RECORD&quot; for the month of February, 2012 documented, &quot;...Paint area to right plantar aspect with Betadine daily...&quot; This treatment was started 2/20/12.</td>
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<td>Review of the care plan dated 7/4/11, updated 9/1/11 and 2/20/12 documented, &quot;...Problem, Need, Strength, Potential Concern... Resident has POTENTIAL FOR pressure ulcer(s)... Approach... Notify nurse immediately of any new areas of skin breakdown, redness, blisters, discoloration noted during bathing or daily care...&quot; There was no documentation of any treatment or of a wound by a nurse until 2/20/12 after the lesion was noted 2/18/12 by the CNA.</td>
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<td>Observations in Resident #5's room on 3/25/12 at 3:23 PM, revealed Resident #5 lying on her right side in the bed, dressing intact to her right foot, an air mattress on the bed, and a heel boot on her right foot.</td>
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<td>Observations in Resident #5's room on 3/26/12 at 8:31 AM, revealed Resident #5 lying in the bed, an air mattress on the bed, a heel boot on her right foot.</td>
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<td>Observations in Resident #5's room on 3/27/12 at 8:10 AM, revealed Resident #5 lying on her right side, bilateral feet on the mattress, and no pillows between her legs.</td>
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F 272 Continued From page 4

Observations in Resident #5's room on 3/27/12 at 10:25 AM, during a dressing change with Nurse #4, revealed Resident #5 lying on her left side, a wound to the ball of the right foot circular, some slough to the edges, and granulation tissue to the center of the wound, her great toe turned upright at the joint, and contracted at the ankles and knees.

Observations in Resident #5's room on 3/27/12 at 3:46 PM, revealed Resident #5 lying supine with a heel boot to her right foot.

During an interview at the 2nd floor nurses' station on 3/28/12 at 4:25 PM, Nurse #4 (Treatment Nurse) stated, "She [Resident #5] has an open area to the planter region of her right foot. It was a necrotic area when it started. Nurse #4 was asked if the wound was in-house acquired. Nurse #4 stated, "Yes, it started here." Nurse #4 was asked what preventive measures were in place before the wound was identified. Nurse #4 stated, "We didn't have anything for her feet at the time. She is so contracted it is hard to position her."

During a telephone interview in the conference room on 3/27/12 at 11:45 AM, the resident's physician (also the facility's Medical Director) was asked if an area of eschar/necrotic skin could occur from 2/19/12 until 2/20/12 and reviewed the scenario of Resident #5's occurrence of this unstageable pressure ulcer. The resident's physician stated, "Theoretically it could. I'm hard pressed to think it could happen. I'm hard pressed to believe it did. I think it could be Stage II, but to get eschar is highly unlikely. I've not
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seen that occur. It usually begins as red then on to Stage II. Highly unlikely...

During an interview in Resident #5's room on 3/27/12 at 12:02 PM, CNA #1 stated, "...we sometimes use pillows to position but she throws them on floor so we don't use them." CNA #1 was asked if Resident #5 uses heel boots. CNA #1 stated, "uhhuh, just one."

During an interview in the conference room on 3/27/12 at 4:50 PM, Resident #5's physician stated, "They have produced those papers [C.N.A SKIN CARE ALERT form] of documentation that something was found on the 18th [2012]. That changes the view of this wound occurring. From the beginning on the 18th [2012] until the 20th [2012] it could have progressed."

The facility had no documentation of any treatment or documentation of a wound by a nurse until 2/20/12, when the area is "...Resident noted with area of eschar plantar aspect..." Eschar is unstageable.

During an interview in the conference room on 3/27/12 at 5:00 PM, Nurse #8 was asked what preventive measures were put into place on the 18th when the change was noted on the foot. Nurse #8 stated, "She [Resident #5] already had boots when she would wear them. They tried to use them on her when she would wear them... The CNA put the sheet in a folder for me. She [CNA] would have put it in my folder on Friday. It was the 18th [2012]. I would not have known about it until Monday and that is when the treatment was started." Nurse #8 was asked what was done differently starting on the 18th when the...
F 272 Continued From page 6

area was found. Nurse #8 stated, "Just the boots."

The facility's failure to properly assess and identify skin breakdown prior to the development of an unstageable pressure ulcer resulted in actual harm to Resident #5.

The facility's failure to properly assess and identify skin breakdown prior to the development of an unstageable pressure ulcer resulted in actual harm to Resident #5.

2. Medical review for Resident #189 documented an admission date of 10/12/11 with diagnoses of Left Eye Prostheses, Colon Cancer, Diabetes, Anemia, Hypertension, History of Cerebrovascular Accident, Pleural Effusion and History of Left Cranectomy. Review of the admission Minimum Data Set (MDS) with an assessment reference date of 10/18/11 documented Resident #189 with impaired vision and corrective lenses used. Review of the quarterly MDS with an assessment reference date of 1/12/12 documented Resident #189 with impaired vision and no corrective lenses used.

Observations in Resident #189's room on 3/25/12 at 3:20 PM and on 3/26/12 at 4:35 PM, revealed Resident #189 seated in a wheelchair in his room, with glasses on the night stand.

Observations in Resident #189's room on 3/27/12 at 6:15 PM, revealed Resident #189 seated in a wheelchair in his room eating supper meal and watching television, with glasses on the night stand.
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<th>(x5) COMPLETION DATE</th>
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<td>F 272</td>
<td>Continued From page 7</td>
<td>F 272</td>
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<td>During an interview in Resident #189's room on 3/28/12 at 6:40 AM, Resident #189 stated he does wear glasses, mostly for reading. Resident #189 stated, &quot;I need them [glasses] all the time but I wear the glasses to read something.&quot; Resident #189 was asked if the staff remind him to wear the glasses and he stated, &quot;No, I wear them when I want to.&quot;</td>
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<td>During an interview at the 2nd floor nurses' station on 3/28/12 at 9:00 AM, Nurse #6 was asked if Resident #189 has any vision problems. Nurse #6 stated, &quot;Not that I'm aware of.&quot; Nurse #6 was asked if Resident #189 wears glasses. Nurse #6 stated, &quot;I don't know. I'm not sure.&quot;</td>
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<td>During an interview at the 2nd floor nurses' station on 3/28/12 at 9:15 AM, Nurse #8 was asked if Resident #189 wears glasses. Nurse #8 stated, &quot;He has glasses and usually wears when he wants to wear them.&quot; Nurse #8 was asked if the quarterly MDS was correct for no corrective lenses. Nurse #8 stated, &quot;that must be a typo. It's not right. He has glasses.&quot;</td>
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<tr>
<td>F 278</td>
<td>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</td>
<td>F 278</td>
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<td>SS=D</td>
<td>The assessment must accurately reflect the resident's status.</td>
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<td>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</td>
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<td>A registered nurse must sign and certify that the assessment is completed.</td>
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<td>Each individual who completes a portion of the</td>
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| F 278 | Continued From page 8 assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, it was determined the facility failed to accurately assess a foley catheter, vision and/or weight for 3 of 16 (Residents #130, 189 and 220) sampled residents of the 40 residents included in the Stage 2 review. The findings included: 1. Medical record review for Resident #130 documented an admission date of 12/1/10 with diagnoses of Dementia, Dysphagia, Percutaneous Endoscopy Gastrostomy, Chronic Kidney Disease, Hypertension, Congestive Heart Failure, Glaucoma, Coronary Artery Disease, Benign Prostatic Hypertrophy, Arthritis, History Urinary Tract Infection (UTI), Hypercholesteremia and Urinary Retention. Review of the quarterly
<p>| F 278 | Immediate Interventions: 1. Resident #130, #189, &amp; #220's MDS was reviewed for foley catheters, glasses, vision, and weight loss assessments and immediately corrected by the MDS coordinator by 3/28/12. Identification of the residents with potential to be affected: 2. All MDS assessments were reviewed by MDS coordinators for accuracy for Foley catheters, glasses, vision, and weight loss assessments by 4/4/12. Measures to prevent recurrence: 3. MDS coordinators in-serviced by administrator/designee on resident assessment accuracy relating to Foley catheters, vision, glasses, and weight loss 4/12/12, monthly, pmn and orientation. Monitoring: 4. All MDS assessments will be audited by the DON or designee weekly for four weeks, monthly for four weeks, then pmn for accuracy of catheters, visual, glasses, and weight loss with variances immediately corrected by the MDS coordinator and reported to the administrator. All variances reported to QA monthly for input and recommendation by 4/12/12. | 3/28/12 | 4/4/12 | 4/12/12 | 4/12/12 |</p>
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| F 278         | Continued From page 9  
Minimum Data Set (MDS) with an assessment reference date of 12/5/11 documented Resident #130 as always incontinent and with no catheter.  
Review of a hospital "MEDICAL RECORD" progress note dated 11/23/11 documented, "...He [Resident #130] was recently hospitalized in [Nursing Home] records at [Named Hospital] on 11/10/2011. He was treated for UTI w [with] enterococcus... Was on terazosin for BPH [begin prostate hypertrophy] but now will likely require Foley..."  
Review of the facility's recertification orders dated 2/2/12 documented, "...FOLEY CATHETER DX [diagnosis]: URINARY RETENTION... CHANGE CATHETER MONTHLY AND PRN [as needed]..." with a start date of 11/28/11. Review of the "NURSING ADMISSION INFORMATION... SYSTEM EVALUATION" dated 11/28/11 documented Resident #130 with a foley catheter.  
During an interview in the 4th floor social service's office on 3/28/12 at 10:20 AM, MDS Coordinator #1 confirmed the 12/5/11 quarterly MDS was inaccurate concerning the foley catheter, and stated, "...yta, [the catheter] should have been reflected on there [the MDS]...
2. Medical review for Resident #189 documented an admission date of 10/12/11 with diagnoses of Left Eye Prostheses, Colon Cancer, Diabetes, Anemia, Hypertension, History of Cerebrovascular Accident, Pleural Effusion, and History of Left Craniotomy. Review of the admission MDS with an assessment reference date of 10/18/11 documented Resident #189 with impaired vision and corrective lenses used. |
**F 278** Continued From page 10

Review of the quarterly MDS with an assessment reference date of 1/12/12 documented Resident #189 with impaired vision and no corrective lenses used.

Observations in Resident #189’s room on 3/25/12 at 3:20 PM and on 3/26/12 at 4:35 PM, revealed Resident #189 seated in a wheelchair in his room, with glasses on the night stand.

Observations in Resident #189’s room on 3/27/12 at 6:15 PM, revealed Resident #189 seated in a wheelchair in his room eating the supper meal and watching television, with glasses on the night stand.

During an interview in Resident #189’s room on 3/28/12 at 8:40 AM, Resident #189 stated he does wear glasses, mostly for reading. Resident #189 stated, "I need them [glasses] all the time but I wear the glasses to read something." Resident #189 was asked if the staff remind him to wear the glasses and he stated, "No, I wear them when I want to."

During an interview at the 2nd floor nurses' station on 3/28/12 at 9:00 AM, Nurse #6 was asked if Resident #189 has any vision problems. Nurse #6 stated, "Not that I’m aware of." Nurse #6 was asked if Resident #189 wears glasses. Nurse #6 stated, "I don’t know. I’m not sure."

During an interview at the 2nd floor nurses' station on 3/28/12 at 9:15 AM, Nurse #8 was asked if Resident #189 wears glasses. Nurse #8 stated, "He has glasses and usually wears when he wants to wear them." Nurse #8 was asked if the quarterly MDS was correct for no corrective...
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**ID** | **SUMMARY STATEMENT OF DEFICIENCIES**
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F 278 | Continued From page 11

**NAME OF PROVIDER OR SUPPLIER**

SIGNATURE HEALTHCARE AT ST PETER VILLA

**STREET ADDRESS, CITY, STATE, ZIP CODE**

141 N MCLEAN
MEMPHIS, TN 38104

| **ID** | **SUMMARY STATEMENT OF DEFICIENCIES** | **ID** | **SUMMARY STATEMENT OF DEFICIENCIES** |
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F 278 | Continued From page 11 | F 278 | Continued From page 11

3. Medical record review for Resident #220 documented an admission date of 1/25/12 with diagnoses of Encephalopathy, Weakness, Degenerative Joint Disease, Acute Hypoxemia, Coumadin Treatment for Atrial Fibrillation, Respiratory Failure, History of Lung Cancer, Colon Cancer, Prostate Cancer, Diabetes, Hypertension, History of Ethanol abuse, Dementia, History of Brain Cancer and Chronic Pain. Review of the admission MDS with an assessment date of 2/1/12 documented Resident #220 with no weight loss of 5 percent (%) or more in last month or 10% or more in last 6 months, impaired vision and uses corrective lenses. Review of the 30 day MDS with an assessment reference date of 2/22/12 documented Resident #220 with a weight loss of 5% or more in last month or 10% or more in last 6 months, impaired vision and no corrective lenses.

Review of a hospital History and Physical dated 1/19/12 documented, "...He [Resident #220] is a well-developed, overweight white male..."

Further medical record review of the facility's "Monthly/Weekly Weight Record" for Resident #220 documented an admission weight of 177.4 on 1/25/12, 178 on 1/26/12, 181.2 on 2/4/12, 178 on 2/8/12, 181.3 on 2/15/12, 178.4 on 2/22/12 and 182.4 on 3/3/12. Review of the "Nursing Admission Information" documented right and left vision as poor.

Observations in Resident #220's room on 3/27/12 at 4:00 PM, revealed Resident #220 seated in a
Continued from page 12.

wheelchair visiting with his wife, with his eye
glasses hanging on his shirt.

During an interview in Resident #220's room on
3/27/12 at 4:00 PM, Resident #220 stated he
uses his glasses when needed.

During an interview in the 4th floor social
service's office on 3/27/12 at 3:05 PM, MDS
Coordinator #1 was asked why there was a
discrepancy between each of the MDS
assessments concerning weight loss. MDS
Coordinator #1 stated, "I do not see a weight loss
in this time period, I will correct [the MDS]."

During an interview in the 4th floor social
service's office on 3/27/12 at 3:05 PM, MDS
Coordinator #1 was asked why the admission
MDS assessment documented the resident
wears corrective lenses and the 30 day MDS
documented the resident does not wear
corrective lenses. MDS Coordinator stated,
"When he came in, he did not have any [glasses],
his wife brought them [glasses] later, sometimes
he wears his glasses, sometimes he does not,
sometimes he says cannot find [his glasses]."

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
F 282

Continued From page 13
and interview, it was determined the facility failed to follow interventions and treatment orders for 2 of 16 (Residents #5 and 35) sampled residents reviewed of the 40 residents included in the Stage 2 review.

The findings included:

1. Medical record review for Resident #5 documented an admission date of 12/1/10 with diagnoses of Coronary Artery Disease, Adult Failure to Thrive, Hypertension, Dementia, Congestive Heart Failure, Schizophrenia, Deafness and Blindness. Review of an "INDIVIDUAL SKIN REPORT" dated 2/20/12 documented, "...DATE OF ONSET: 2-20-12 R [right] plantar... Facility Acquired: [check mark]... [check mark] Pressure... [check mark] Unstageable Pressure Ulcers due to slough and/or eschar... Measurements (cm) [centimeters]... L [length] 2.0 W [width] 2.0 D [diameter] U [unstageable]... Type Wound PU [pressure ulcer] Stage U..." Review of the care plan dated 7/4/11, updated 9/1/11 and 2/20/12 documented, "...Problem, Need, Strength, Potential Concern... Resident has POTENTIAL FOR pressure ulcer(s)... Approach... Avoid skin to skin contact... Minimize pressure over bony prominences... USE PILLOWS TO HIGH PAD HIGH RISK AREAS... 2/20/12 Tx [treatment] as ordered heel boots to protect..."

Observations in Resident #5's room on 3/25/12 at 3:23 PM, revealed Resident #5 lying on her right side in the bed, a dressing intact to her right foot, an air mattress on the bed, and a heel boot on her right foot.

Immediate Interventions:
1. Resident #5's care plan was immediately reviewed for appropriateness of positioning devices including heel boots and utilized pillows by MDS coordinator 3/28/12

2. Resident #35's care plan and treatment administration record and documentation was reviewed for accuracy, appropriateness, and completion by MDS coordinator and wound care nurse by 3/28/12.

Identification of the residents with potential to be affected:
3. 100% resident's most recent care plans reviewed by MDS coordinators and wound care nurse for accuracy and appropriateness of positioning devices with variance corrected and results to DON and administrator by 3/30/12.

4. 100% March treatment administration record reviewed for accuracy and completion by DON or designee with results reported to administrator by 3/30/12.

Measures to prevent recurrence:
5. 100% C.N.A.'s and nursing staff in-serviced to ensure care planned positioning devices are in place as ordered with training in orientation, monthly and per 4/12/12.

6. 100% nursing staff including treatment nurse in-serviced on proper wound care documentation including treatment administration record by staff development coordinator/designee 4/10/12, in orientation, monthly and per 4/12/12.
Continued From page 14
Observations in Resident #5's room on 3/26/12 at 8:31 AM, revealed Resident #5 lying in the bed, an air mattress on the bed, a heel boot on her right foot.

Observations in Resident #5's room on 3/27/12 at 8:10 AM, revealed Resident #5 lying on her right side, bilateral feet on the mattress, with no pillows between her legs.

Observations in Resident #5's room on 3/27/12 at 10:25 AM, during a dressing change with Nurse #4, revealed Resident #5 lying on her left side, a wound to the ball of the right foot circular, some slough to the edges, and granulation tissue to the center of the wound, her great toe turned upright at the joint, and contracted at the ankles and knees.

Observations in Resident #5's room on 3/27/12 at 3:46 PM, revealed Resident #5 lying supine with a heel boot to her right foot.

During an interview at the 2nd floor nurses' station on 3/26/12 at 4:25 PM, Nurse #4 stated, "She [Resident #5] has an open area to the plantar region of her right foot. It was a necrotic area when it started. Nurse #4 was asked if the wound was in-house acquired. Nurse #4 stated, "Yes, it started here." Nurse #4 was asked what preventive measures were in place before the wound was identified. Nurse #4 stated, "We didn't have anything for her feet at the time. She is so contracted it is hard to position her."

During an interview in Resident #5's room on 3/27/12 at 12:02 PM, Certified Nursing Assistant (CNA) #1 stated, "...we sometimes use pillows to
Continued From page 15

position but she throws them on floor so we don't use them..." CNA #1 was asked if Resident #5 uses heel boots. CNA #1 stated, "uhhuh, just one."

During an interview in the conference room on 3/27/12 at 5:00 PM, Nurse #8 was asked what preventive measures were put into place on the 19th when the change was noted on the foot. Nurse #8 stated, "She already had boots when she would wear them. They tried to use them on her when she would wear them..."

2. Medical record review for Resident #35 documented an admission date of 12/24/02 with diagnoses of Alzheimer's Dementia, Diabetes, Hypertension, Hyponatremia, Dysphagia with Percutaneous Endoscopy Gastrostomy (PEG) and Fecal/Urinary Incontinence. Review of the "INDIVIDUAL SKIN REPORT" documented, "DATE OF ONSET: 8-1-11 RIGHT GLUTEUS...Type Wound SHEAR Stage PARTIAL... DATE OF ONSET: 8-1-11 LEFT GLUTEUS... Type Wound SHEAR Stage PARTIAL..." Review of the "DECUBITUS / PRESSURE ULCER REPORT" documented Stage 2 decubitus wounds to right and left gluteal first observed as 9/9/11. Review of the physician's recertification orders dated 9/7/11 documented, "...8-1-11 Clean gluteal wounds c [with] NS [normal saline] [and] apply hydrofera blue q [every] 2- to 3 days [and] prn [as needed]..." Review of the care plan dated 12/27/11 documented to provide treatments as ordered as an intervention. Review of the August, 2011 Treatment Record documented, "...Clean R [and] L gluteal wounds c NS [and] apply hydrofera blue q 2-3 days [and] prn..." There were no documented treatments from 8/13/11 through (-)
NAME OF PROVIDER OR SUPPLIER: SIGNATURE HEALTHCARE AT ST PETER VILLA
STREET ADDRESS, CITY, STATE, ZIP CODE: 141 N MCLEAN
MEMPHIS, TN 38104

<table>
<thead>
<tr>
<th>(X4) ID PREFIX</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID PREFIX</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 282</td>
<td>Continued From page 16 8/17/11 or from 8/20/11-8/31/11. Review of the September, 2011 Treatment Record (TAR) documented, &quot;...Clean R [and] L gluteal wounds c NS [and] apply hydrofena blue q 2-3 days [and] pm...&quot; with a DC [discontinue] date of 9/22/11. There were no documented treatments from 9/8/11-9/13/11 and from 9/16/11-9/18/11. The care plan intervention to provide treatments as ordered was not followed. Observations in Resident #35's room on 3/27/12 at 3:15 PM, revealed Resident #5 in bed, on her back, eyes closed, the head of bead elevated, upper 1/4 side rails up, Nepro infusing per PEG, with an air mattress on the bed. Observations in Resident #35's room on 3/28/12 at 8:45 AM, revealed Resident #35 lying on her right side, with wedge and pillow for positioning, Nepro infusing per PEG, 1/4 upper side rails up, the head of bed elevated 30 degrees, and an air mattress present on the bed. During an interview in the conference room on 3/27/12 at 6:30 PM, Nurse #4 was asked about documentation on the September 2011 TAR. Nurse #4 (Treatment Nurse) stated, &quot;...someone wrote over dates as August but I believe this is the September TAR, I started on 9/22/11 and got new orders for the wounds, the previous treatment nurse had a heart attack...&quot;</td>
<td>F 282</td>
<td></td>
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</tr>
<tr>
<td>F 314</td>
<td>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</td>
<td>F 314</td>
<td>Signature Healthcare at St. Peter Villa will continue to ensure that residents who enter the facility without pressure sores do not develop pressure sores unless their individual clinical condition demonstrates that they were unavoidable.</td>
<td></td>
</tr>
</tbody>
</table>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: 445139

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED 03/28/2012

NAME OF PROVIDER OR SUPPLIER

SIGNATURE HEALTHCARE AT ST PETER VILLA

STREET ADDRESS, CITY, STATE, ZIP CODE
141 N MCLEAN
MEMPHIS, TN 38104

<table>
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<th>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>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 314</td>
<td>Continued From page 17 individuals'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 review of the &quot;National Pressure Advisory Panel [NPUAP] Pressure Ulcer Prevention QUICK REFERENCE GUIDE&quot;, policy review, medical record review, observation and interview, it was determined the facility failed to properly assess residents for pressure ulcers, and/or follow interventions and treatment orders for 2 of 4 (Residents #5 and 35) sampled residents reviewed of the 7 residents with in house acquired decubiti wounds. The facility's failure to properly assess and identify skin breakdown prior to the development of an unstageable pressure ulcer resulted in actual harm to Resident #5. The findings included: 1. Review of the &quot;National Pressure Advisory Panel Pressure Ulcer Prevention QUICK REFERENCE GUIDE&quot; documented, &quot;...Unstageable/Unclassified: Full thickness skin or tissue loss-depth unknown Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown, or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV...&quot;</td>
<td>F 314</td>
<td>Signature Healthcare at St. Peter Villa will continue to ensure that a resident having pressure sores receive the necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Immediate Interventions: 1. Resident #5 &amp; #35 were assessed to ensure positioning devices in place 3/28/12 as ordered by DON and wound care nurse. 2. Resident #5 &amp; #35's treatment order and treatment administration records were reviewed for accuracy, appropriateness and completion by wound care nurse, DON 3/28/12. Identification of the residents with potential to be affected: 3. 100% skin audits of all residents completed by 3/29/12, weekly for four weeks, monthly, and pm by nursing management with results to DON and administrator immediately with variances corrected, nursing staff in-serviced, and variances to QA monthly for input &amp; recommendations. 4. All residents with wounds assessed for size, location, appropriate treatment and positioning devices by 3/30/12 and weekly by wound care nurse with results to DON, administrator immediately, and QA monthly for input and recommendations. Measures to prevent recurrence: 5. 100% all nursing staff in-serviced on wound prevention, immediate assessment, treatment intervention initiation and documentation procedures by 4/12/12 with in-servicing done in orientation, monthly and pm by staff development coordinator or designee.</td>
<td>3/28/12</td>
</tr>
</tbody>
</table>
### F 314

Continued From page 18

- 3. Inspect skin regularly for signs of redness... Ongoing assessment of the skin is necessary to detect early signs of pressure damage. 4. Skin inspection should include assessment for localized heat, edema, or induration (hardness), especially in individuals with darkly pigmented skin..."

Review of the facility's "Skin Care Protocol" policy documented, "...New skin breakdown A Treatment nurse, nurse manager, M.D. [Medical Doctor], and D.O.N. [Director of Nursing], notified of new breakdown B Treatment nurse examines, writes, and initiates orders...

Medical record review for Resident #5 documented an admission date of 12/1/10 with diagnoses of Coronary Artery Disease, Adult Failure to Thrive, Hypertension, Dementia, Congestive Heart Failure, Schizophrenia, Deafness, and Blindness. Review of a "C.N.A. [Certified Nursing Assistant] SKIN CARE ALERT" form dated 2/18/12 documented a lesion to Resident #5's right foot. Review of a "DAILY SKILLED NURSE'S NOTE" dated 2/19/12 documented, "...Skin WNL [within normal limits] [check mark]..." Review of a "DAILY SKILLED NURSE'S NOTE" date 2/20/12 documented, "...Skin WNL [within normal limits] [check mark]..." and a narrative documented "...Resident noted with area of eschar plantar aspect. New order received for Betadine daily..."

Review of an "INDIVIDUAL SKIN REPORT" dated 2/20/12 documented, "...DATE OF ONSET: 2-20-12 R [right] plantar... Facility Acquired [check mark]...[check mark] Pressure...[check mark] Unstageable Pressure Ulcers due to

### F 314

6.100% weekly skin audits to be reviewed by DON and wound care nurse for appropriate intervention, treatment and documentation with variances corrected, staff in-serviced and results to administrator immediately and QA monthly for input and recommendation 4/6/12.

Monitoring:
7. DON or designee to audit weekly five residents for potential skin issues with variances corrected, staff in-serviced, variances to administrator immediately and report to QA monthly for input and recommendations 4/12/12.

8. All skin issues identified will be placed on 24 hour report and discussed in clinical and at risk meeting with nursing management, certified dietary manager, social services, and wound care nurse to ensure all interventions, treatments, positioning devices and documentation is in place with variances corrected, staff in-serviced and findings to administrator immediately, QA monthly for input and recommendation 4/6/12

9. DON or designee to perform rounds with treatment nurse weekly on three residents to ensure appropriate treatment, staging, interventions including positioning devices in use with all variances corrected, staff in-serviced with variance reported to administrator immediately and QA monthly for input and recommendations 4/12/12.

10. Daily quality rounds for four weeks then monthly and pm by administrative staff or designee for positioning devices and interventions with variances corrected, staff in-serviced and results to administrator immediately and QA monthly for input and recommendations 4/12/12.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

((X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER: 445139)

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

((X3) DATE SURVEY COMPLETED 03/28/2012)

NAME OF PROVIDER OR SUPPLIER

SIGNATURE HEALTHCARE AT ST PETER VILLA

STREET ADDRESS, CITY, STATE, ZIP CODE
141 N MCLEAN
MEMPHIS, TN 38104

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

F 314 Continued From page 19
slough and/or eschar... Measurements (cm) [centimeters]... L [length] 2.0 W [width] 2.0 D [diameter] U [unstageable]... Type Wound PU [pressure ulcer] Stage U [unstageable]...

Review of a "Weekly Skin Rounds" documented the following:
  a. 2/15/12, "...Skin Condition: clear..."
  b. 2/20/12, "...Skin Condition: Rt [right] foot Ball of foot below great toe..."
  c. 2/22/12, "Skin Condition: Good... Necrosis R [right] gt [great] toe unchanged..."

Review of Resident #5's "TREATMENT RECORD" for the month of February, 2012 documented, "...Paint area to right plantar aspect with Betadine daily..." This treatment was started 2/20/12.

Review of the care plan dated 7/4/11, updated 9/1/11 and 2/20/12 documented, "...Problem, Need, Strength, Potential Concern... Resident has POTENTIAL FOR pressure ulcer (s)... Approach... Notify nurse immediately of any new areas of skin breakdown, redness, blisters, discoloration noted during bathing or daily care... Avoid skin to skin contact... Minimize pressure over bony prominence's... USE PILLOWS TO PAD HIGH RISK AREAS... 2/20/12 Tx [treatment] as ordered heel boots to protect..." There was no documentation of any treatment or of a wound by a nurse until 2/20/12 after the lesion was noted on 2/18/12 by the Certified Nursing Assistant (CNA).

Observations in Resident #5's room on 3/25/12 at 3:23 PM, revealed Resident #5 lying on her right side in the bed, a dressing intact to her right foot,
**F 314**

Continued From page 20

an air mattress on the bed and a heel boot on her right foot.

Observations in Resident #5's room on 3/26/12 at 8:31 AM, revealed Resident #5 lying in the bed, an air mattress on the bed, a heel boot on her right foot.

Observations in Resident #5's room on 3/27/12 at 8:10 AM, revealed Resident #5 lying on her right side, bilateral feet on the mattress, with no pillows between her legs.

Observations in Resident #5's room on 3/27/12 at 10:25 AM, during a dressing change with Nurse #4, revealed Resident #5 lying on her left side, a wound to the ball of the right foot circular, some slough to the edges, and granulation tissue to the center of the wound, her great toe turned upright at the joint, and contracted at the ankles and knees.

Observations in Resident #5's room on 3/27/12 at 3:46 PM, revealed Resident #5 lying supine with a heel boot to her right foot.

During an interview at the 2nd floor nurses station on 3/26/12 at 4:25 PM, Nurse #4 (Treatment Nurse) stated, "She [Resident #5] has an open area to the planter region of her right foot. It was a necrotic area when it started. Nurse #4 was asked if the wound was in-house acquired. Nurse #4 stated, "Yes, it started here." Nurse #4 was asked what preventive measures were in place before the wound was identified. Nurse #4 stated, "We didn't have anything for her feet at the time. She is so contracted it is hard to position her."
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During a telephone interview in the conference room on 3/27/12 at 11:45 AM, Resident #5's physician (also the facility's Medical Director) was asked if an area of eschar/necrotic skin could occur from 2/19/12 until 2/20/12 and reviewed the scenario of Resident #5's occurrence of this unstable pressure ulcer. Resident #5's physician (also facility's medical director) stated, "Theoretically it could. I'm hard pressed to think it could happen. I am hard pressed to believe it did. I think it could be Stage II, but to get eschar is highly unlikely. I've not seen that occur. It usually begins as red then on to Stage II. Highly unlikely..."

During an interview in Resident #5's room on 3/27/12 at 12:02 PM, CNA #1 stated, "...we sometimes use pillows to position but she throws them on floor so we don't use them..." CNA #1 was asked if Resident #5 uses heel boots. CNA #1 stated, "uhuh, just one."

During an interview in the conference room on 3/27/12 at 4:50 PM, Resident #5's physician stated, "They have produced these papers ['C.N.A SKIN CARE ALERT' form] of documentation that something was found on the 18th [2012]. That changes the view of this wound occurring. From the beginning on the 18th [2012] until the 20th [2012] it could have progressed..."

There was no documentation of treatment or documentation of a wound by a nurse until 2/20/12.

During an interview in the conference room on 3/27/12 at 5:00 PM, Nurse #8 was asked what preventive measures were put into place on the 18th [2012] when the change was noted on the
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foot. Nurse #6 stated, "She already had boots when she would wear them. They tried to use them on her when she would wear them... The CNA put the sheet in a folder for me. She [CNA] would have put it in my folder on Friday. It was the 18th [2012]. I would not have known about it until Monday and that is when the treatment was started." Nurse #6 was asked what was done differently starting on the 18th when the area was found. Nurse #8 stated, "Just the boots."

The facility’s failure to properly assess and identify skin breakdown prior to the development of an unstageable pressure ulcer resulted in actual harm to Resident #5.

2. Medical record review for Resident #35 documented an admission date of 12/24/02 with diagnoses of Alzheimer’s Dementia, Diabetes, Hypertension, Hyponatremia, Dysphagia with a Percutaneous Endoscopy Gastrostomy (PEG), and Fecal/Urinary Incontinence.

Review of the "INDIVIDUAL SKIN REPORT" documented, "...DATE OF ONSET: 8-1-11 RIGHT GLUTEUS... Type Wound SHEAR Stage PARTIAL... DATE OF ONSET: 8-1-11 LEFT GLUTEUS... Type Wound SHEAR Stage PARTIAL..." Review of the "DECUBITUS / PRESSURE ULCER REPORT" documented Stage 2 decubitus wounds to right and left glutaeal first observed as 9/9/11. Review of the physician’s recertification orders dated 9/7/11 documented, "...8-1-11 Clean glutaeal wounds c [with] NS [normal saline] [and] apply hydrofera blue q [every] 2- [to] 3 days [and] prn [as needed]..."
<table>
<thead>
<tr>
<th>F 314</th>
<th>Continued From page 23</th>
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<tr>
<td></td>
<td>Review of the care plan dated 12/27/11 documented to provide treatments as ordered as an intervention. Review of the August, 2011 Treatment Record documented, &quot;...Clean R [and] L gluteal wounds c NS [and] apply hydrofera blue q 2-3 days [and] pm...&quot; There were no documented treatments from 8/13/11 through (-) 8/17/11 or from 8/20/11-8/31/11. Review of the September, 2011 Treatment Record (TR) documented, &quot;...Clean R [and] L gluteal wounds c NS [and] apply hydrofera blue q 2-3 days [and] pm...&quot; with a DC [discontinue] date of 9/22/11. There was no documentation that treatments were done from 9/8/11-9/13/11 and from 9/16/11-9/18/11.</td>
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<td>Observations in Resident #35's room on 3/27/12 at 3:15 PM, revealed Resident #5 in bed, on her back, eyes closed, the head of bead elevated, upper 1/4 side rails up, Nepro infusing per PEG, with an air mattress on the bed.</td>
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<td>During an interview in the conference room on 3/27/12 at 6:30 PM, Nurse #4 was asked about documentation on the September 2011 TR. Nurse #4 (Treatment Nurse) stated, &quot;...someone wrote over dates as August but I believe this is the September TR, I started on 9/22/11 and got new orders for the wounds, the previous treatment nurse had a heart attack...&quot;</td>
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<tr>
<th>F 315</th>
<th>483.25(d) NO CATHETER, PREVENT UTI,</th>
</tr>
</thead>
</table>

**Signature Healthcare At ST Peter Villa**

**Street Address, City, State, Zip Code**

141 N McLean
MEMPHIS, TN 38104
**Signature Healthcare at St. Peter Villa**

**Street Address, City, State, Zip Code**
141 N McLean
Memphis, TN 38104

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<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
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<tr>
<td>F315</td>
<td>Continued from page 24 RESTORE BLADDER</td>
<td>F315 Signature Healthcare at St. Peter Villa will continue to ensure that residents who are incontinent of bladder receive appropriate treatment to prevent urinary tract infections and to restore as much normal bladder function as possible.</td>
</tr>
</tbody>
</table>
| SS=D | 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. | Immediate Interventions: 
1. Resident #130 & #188 Foley catheter tubing and bags were immediately positioned correctly by nursing staff 3/28/12. 
2. 100% all residents with Foley catheters were assessed by licensed nurses to ensure proper placement of catheter tubing and bags immediately completed 3/28/12. 
3. 100% all nursing staff in-serviced by staff development coordinator or designee on proper Foley tubing and bag positioning by 4/12 and will be completed for all nursing staff in orientation, monthly, and pm. |

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 provide appropriate treatment and services by allowing urinary drainage bags and tubing to touch the floor for 2 of 2 (Resident #130 and 188) sampled residents reviewed of the 2 residents included in the Stage 2 review with a foley catheter.

The findings included:

1. Review of the facility's "FOLEY CATHETER CARE" policy documented, "...Catheter tubing should be arranged so it doesn't kink or hang in a dependent loop..."

2. Medical record review for Resident #130 documented an admission date of 12/1/10 with diagnoses of Percutaneous Endoscopic Gastrostomy, Dementia, Dysphagia, Hypertension, Congestive Heart Failure, Glaucoma, Coronary Artery Disease, Benign
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CUA Identification Number:** 445139  
**Multiple Construction:**  
A. Building  
B. Wing  
**Date Survey Completed:** 03/26/2012

#### Signature Healthcare at St Peter Villa

**Street Address, City, State, Zip Code:** 141 N McLean, Memphis, TN 38104

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</table>
| F 315  | Continued from page 25  
Prostatic Hypertrophy, Chronic Kidney Disease, Arthritis, History Urinary Tract Infection, Hypercholesteremia and Urinary Retention.  
Review of the 2/12/12 recertification orders documented, "...FOLEY CATHETER DX [diagnosis]: URINARY RETENTION... CATHETER CARE EVERY SHIFT ANCHOR TUBING..."  
Observations on the 4th floor hall on 3/25/12 at 11:55 AM, revealed Resident #130 being propelled by a staff member, with the Foley catheter in a privacy bag with privacy bag being drug on the floor.  
Observations in the sitting area on the 4th floor on 3/25/12 at 10:03 AM, revealed Resident #130 seated in a wheelchair with the foley catheter tubing laying on the floor, and the resident's shoe on the tubing.  
Observations on the 4th floor in front of the elevator on 3/27/12 at 2:50 PM, revealed Resident #130 sitting in a wheelchair, with the foley catheter tubing laying on the floor.  
Observations on the 4th floor in the sitting area on 3/28/12 at 8:55 AM, revealed Resident #130 seated in a wheelchair, with the foley catheter tubing laying on the floor.  
3. Medical record review for Resident #188 documented an admission date of 10/20/2011 with diagnoses of Right Lower Lobe Infiltrate, Pneumonia, Dementia, Hypertension and Benign Prostatic Hypertrophy. Review of recertification orders dated 3/23/12 documented "...FOLEY CATHETER... ANCHOR TUBING... CATHETER..." | F 315  |                                                                                                      |                   |
F 315 Continued From page 26
CARE EVERY SHIFT...

Observations across from the 4th floor nurses’ station on 3/27/12 at 12:10 PM, revealed
Resident #188 seated at a table with a foley catheter in a privacy bag under the wheelchair
with the Foley catheter tubing laying on the floor.

During an interview in the Director of Nursing’s (DON) office on 3/27/12 at 4:45 PM, the DON
was asked if it was acceptable for a privacy bag with a foley catheter bag to be on the floor. The
DON stated, “No...” The DON was then asked if it is acceptable for foley catheter tubing to be on
the floor. The DON stated, “No.”

F 371 483.35(i) FOOD PROCURE,
STORE/PREPARE/SERVE - SANITARY

The facility must -
(1) Procure food from sources approved or
considered satisfactory by Federal, State or local
authorities; and
(2) Store, prepare, distribute and serve food
under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based on policy review, observation and
interview, it was determined the facility failed to
ensure food was prepared or stored under
sanitary conditions as evidenced by wash and
rinse temperatures of the dishwasher were too
low; two pans had a carbon build up on them and
3 of 20 Certified Nursing Assistants (CNAs #2, 3

Signature HealthCare at St. Peter Villa will continue
to ensure procure food from sources approved or
considered satisfactory by Federal, State or local
authorities; and store, prepare, distribute and serve
food under sanitary conditions

Immediate Interventions:
1. The dish wash machine was turned off and reset
by dietary staff. Ecolab and maintenance was
notified upon identifying the concern. All dishes
were re-washed at the proper temperature to ensure
dishes were properly sanitized verified by the
certified dietary manager on 3/25/12.

2. All pans/trays were checked for carbon by
certified dietary manager build up. The trays
identified with the carbon build-up were
immediately removed from rotation and disposed of
3/28/12. Removed all other trays with carbon build
up and used carbon off cleaner to remove any noted
carbon build up 3/29/12.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**: SIGNATURE HEALTHCARE AT ST PETER VILLA

**STREET ADDRESS, CITY, STATE, ZIP CODE**: 141 N MCLEAN, MEMPHIS, TN 38104

**ID**: F 371

**COMPLETION DATE**: 4/9/12

<table>
<thead>
<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>
</tr>
</thead>
</table>
| F 371 | | Continued From page 27 and 4) failed to practice sanitary hand hygiene while serving meal trays during dining observations. The findings included:

1. Review the facility's "DISHMACHINE PROCEDURE" policy documented, "...12. If dish machine temperature is lower than 180 degrees [Fahrenheit (F)] wash or 180 degrees [F] rinse, turn machine off, call maintenance, and contact [Named Provider] to correct before washing any more dishes..."

Review of the facility's "Dishwasher Temperature / Chemical Record" for February 2012 documented the breakfast wash temperature was 140 degrees F on 2/7/12, and the rinse temperature for the lunch was 179 degrees on 2/9/12, 178 degrees F on 2/16/12 and 179 degrees F on 2/20/12.

Observations in the dish room on 3/25/12 at 9:50 AM, revealed the dish machine in use with a wash temperature of 150 degrees F and the rinse temperature of 165 degrees F. Dietary Worker #1 (washing dishes) was shown the current temperatures of the machine but continued doing the dishes.

During an interview in the dish room on 3/25/12 at 10:00 AM, Dietary Worker #1 was asked about the dish machine temperatures. Dietary Worker #1 verified temperatures per the machine recommendations.

During an interview in the conference room on 3/25/12 at 10:50 AM, the Dietary Manager verified... |
<table>
<thead>
<tr>
<th>ID Pref</th>
<th>TAG</th>
<th>Statement of Deficiency</th>
<th>ID Pref</th>
<th>TAG</th>
<th>Provider's Plan of Correction</th>
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<tbody>
<tr>
<td>F 371</td>
<td></td>
<td>Continued From page 28</td>
<td>F 371</td>
<td></td>
<td>8. All trays in use will be checked by dietary staff daily X 4 weeks for carbon build-up. Staff will sign off on a checklist daily X 4 weeks and remove any trays with carbon build-up then will check weekly for build-up. Trays that are removed will be immediately treated and dining room staff will be responsible for initial checklist form. Certified dietary manager and assist manager will monitor for compliance. 100% dietary staff in-serviced on carbon build-up and prevention by 4/9/2012. All variances reported to administrator immediately and QA monthly for input and recommendations.</td>
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<td></td>
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<td>the dish machine recommendations, and stated, &quot;...will call [Named Provider]...&quot;</td>
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<td>4/9/2012</td>
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<td></td>
<td>2. Observations in the kitchen on 3/27/12 at 11:20 AM, revealed 2 of 2 shallow metal pans with carbon buildup present.</td>
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<td>4/12/12</td>
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<td>3. Review of the facility's &quot;RESPONSIBILITIES OF NURSING SERVICE AT MEAL TIMES&quot; policy documented, &quot;...8. CNAs will wash hands after contact with any potentially contaminated surfaces prior to serving resident trays.&quot;</td>
<td></td>
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<td>3/30/12</td>
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<tr>
<td></td>
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<td>a. Observations in Room 213 on 3/25/12 at 11:45 AM, CNA #2 placed a tray on the over bed table, moved a chair to the bedside, raised the head of the bed, placed the tray cover on the floor, picked up the tray cover and placed back over the tray. CNA #2 left the room, obtained a clothing protector from clean supplies, placed the clothing protector on the resident, moved the catheter privacy bag from the mattress to the bed frame, tied the catheter onto the bed frame and placed the catheter bag in a privacy bag. CNA #2 did not wash her hands.</td>
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<td>4/12/12</td>
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<td>b. Observations in the 1st floor dining room on 3/27/12 at 11:35 AM, CNA #3 washed and dried her hands, opened a trash can and then closed it with her bare hand. CNA #3 then served residents their meals, touched a wheelchair handle and put mustard on a sandwich. CNA #3 did not wash her hands.</td>
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<td>4/12/12</td>
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<td>c. Observations in the 4th floor dining room on 3/25/12 at 12:00 PM, CNA #4 pulled the lunch cart down the hall and back into the dining room, obtained a tray for a resident, served the tray to</td>
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<td></td>
<td>4/12/12</td>
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<tr>
<td>ID</td>
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<td>TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES</td>
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<tr>
<td>F 371</td>
<td>Continued From page 29</td>
<td>the resident, touched a wheelchair, opened the food, obtained another tray, opened the food, went to another table and opened the food for a resident, patted a resident and put a clothing protector on the resident and took up empty trays from the tables. CNA #4 then walked down the hall and back into the dining room, pulled a chair across the room to another table, picked up a plastic bag of clothing protectors and sat down at a table with residents. CNA #4 then got up and moved a resident in his wheelchair down the hall, touched her right eye, sat down at a table with other residents and began feeding residents. CNA #4 did not wash her hands.</td>
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<tr>
<td>F 431</td>
<td>SS=E</td>
<td>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</td>
<td>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 appropriate accessory and cautionary instructions, and the expiration date when</td>
<td></td>
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</tr>
</tbody>
</table>
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

SIGNATURE HEALTHCARE AT ST PETER VILLA

**STREET ADDRESS, CITY, STATE, ZIP CODE**

141 N MCLEAN

MEMPHIS, TN 38104

---

**F 431** Continued From page 30 applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

---

**F 431**

In accordance with State and Federal laws, the facility will store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

Signature Healthcare at St. Peter Villa will continue to provide separately locked permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

**Immediate Interventions:**
1. All medications identified by surveyor as expired, undated, or unsecured were removed and replaced by licensed nursing. 3/27/12.
2. 100% all med carts and med rooms audited by nursing administration for unsecured, expired, undated, and unopened meds with all variances corrected immediately 3/28/12. Nurses in-serviced with variances reported to the DON and administrator completed 4/9/12.

**Identification of the residents with potential to be affected:**

**Measures to prevent reoccurrence:**
3. 100% of all nurses in-serviced on ensuring all medications are secured, dating all multi dose medications when opened and removal of all expired meds by 4/9/12, in orientation, monthly, and FRN by staff development coordinator or designee.

---

This **REQUIREMENT** is not met as evidenced by:

Based on policy review, observation and interview, it was determined the facility failed to ensure that expired medications were removed from the medication storage area, failed to ensure medications were secured and not left unattended and failed to ensure all medications were labeled in 6 of 11 (3rd floor north hall medication cart, 4th floor west hall medication cart, 4th floor north split medication cart, 2nd floor medication room and 3rd floor medication room) medication storage areas.

The findings included:

1. Review of the facility's "STORAGE OF MEDICATION" policy documented, "...4.1 ...The
Continued from page 31

F 431

medication supply shall only be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications... 14. Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal...

Review of the facility's "MEDICATION ADMINISTRATION-MEDICATION STORAGE" policy documented "...1. All medications are stored in the medication room in either entire cart or medication bins... 15. Multi-dose vials must have puncture date and nurse's initials when originally used... 14... will be used no longer than 30 days..."

Review of the facility's "MEDICATIONS WITH SPECIAL EXPIRATION DATE REQUIREMENTS" documented, "...Eye Drops 60 days after opening... Multidose Vials with Preservative 28 days after opening... PPD [purified protein derivative] (Aplisol, Tubersol) 30 days after opening... GUIDELINES 1. The date of opening should be documented on the container/vial... 4. The beyond use date after initially entering or opening multiple dose vials is 28 days unless otherwise specified by the manufacturer..."

2. Observations on the 3rd floor north hall beside room #321A on 3/27/12 at 10:05 AM, revealed a bottle of Thera M sitting on top of the medication cart. Nurse #3 went into a resident's room leaving the medication unattended on top of the 3rd floor north hall medication cart.

F 431

Monitoring:
4. Nurse manager/supervisors/or designee to audit all med carts and med rooms daily for four weeks, then weekly for four weeks, monthly, then pm for compliance with medication storage procedure for review and D.C.N. or designee to report results monthly to quality assurance committee for input and recommendations initiated 3/28/12. All variances corrected immediately, staff in-serviced, variance reported to the DON and administrator.
F 431 Continued From page 32

During an interview beside the 3rd floor north hall medication on 3/27/12 at 10:05 AM, Nurse #3 was asked why the Thera M medication was left on top of the medication cart. Nurse #3 stated "...I didn't even think about it..."

During an interview in the conference room on 3/28/12 at 11:05 AM, the Director of Nursing stated, "...I don't see anything in there [the policy] that says they can do that [leave medications unattended] it would be better to secure the meds [medications] when they receive them..."

3. Observations on the 4th floor west hall on 3/27/12 at 7:00 PM, revealed the 4th floor west hall medication cart contained an opened bottle of Timolol Maleate Ophthalmic 0.5 percent (%) and 1 opened bottle of Prednisolone Acetate Ophthalmic with no open dates, 1 bottle of Zinc Sulfate 220 milligram (mg) stored past the expiration date of 1/2012.

4. Observations of the 4th floor north hall on 3/27/12 at 6:35 PM, revealed 4th floor north split medication cart contained 3 opened bottles of Novolin R insulin with no open dates, 1 opened Advaır Disc 250-50 with no open date, Fluticasone Propionate Nasal Spray 50 microgram (mcg) with an open date of 1/18/12, 1 opened tube of Nitro-Bid with no open date, 2 opened tubes of Tobradex Ophthalmic Ointment with no open date, 1 bottle of Zinc Sulfate 220 mg expired on 10/2011, 1 can of Benefiber Soluble Dietary Fiber expired 12/2010, 1 vial of Influenza Virus Vaccine opened 11/19/2011, and 1 vial of Liquid Tears opened 10/4/11.
| F 431 | Continued From page 33  
DURING AN INTERVIEW ON 4TH FLOOR NORTH HALL ON 3/27/12 AT 7:05 PM, NURSE #2 STATED, "...WHEN OPEN DATE IT IMMEDIATELY AND ANYTHING OUT OF DATE PUT IN DESTROY BOX."  

DURING AN INTERVIEW ON 4TH FLOOR NORTH HALL ON 3/27/12 AT 7:15 PM, NURSE #5 STATED, "WHEN OPEN...DATE IT AND INITIAL IT."  

5. OBSERVATIONS IN 3RD FLOOR MEDICATION ROOM ON 3/28/12 AT 9:00 AM, REVEALED 2 OPENED VIALS OF TUBERCULIN VACCINE AND 1 OPEN VIAL OF NOVOLG INSULIN WITH NO OPEN DATES.  

DURING AN INTERVIEW AT THE NURSES' STATION ON 3/28/12 AT 9:05 AM, NURSE #7 CONFIRMED STAFF SHOULD DATE BOTTLES WHEN OPENED.  


DURING AN INTERVIEW AT THE 2ND FLOOR NURSES' STATION ON 3/28/12 AT 9:12 AM, NURSE #6 STATED, "NURSES CHECK FOR EXPIRED MEDICATIONS MONTHLY..."  

DURING AN INTERVIEW ON 3/28/12 AT 9:15 AM, THE PHARMACY CONSULTANT STATED, "...I AM THE PHARMACIST AND I CHECK FOR EXPIRED MEDS MONTHLY ALSO."  

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

THE FACILITY MUST ESTABLISH AND MAINTAIN AN INFECTION CONTROL PROGRAM DESIGN TO PROVIDE A SAFE, SANITARY AND COMFORTABLE ENVIRONMENT AND TO HELP PREVENT THE DEVELOPMENT AND TRANSMISSION OF DISEASE AND INFECTION.  

| F 441 | Signature Healthcare at St. Peter Villa has established and will continue to maintain 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.  

| F 441 | Signature Healthcare at St. Peter Villa has established and will continue to maintain 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.
<table>
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<tr>
<th>Provider/Supplier Identification Number: 445139</th>
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<tbody>
<tr>
<td>Date Survey Completed: 03/28/2012</td>
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**NAME OF PROVIDER OR SUPPLIER**

**SIGNATURE HEALTHCARE AT ST PETER VILLA**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

141 N MCLEAN
MEMPHIS, TN 38104

<table>
<thead>
<tr>
<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION)</th>
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<tbody>
<tr>
<td>F 441</td>
<td>Continued From page 34</td>
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<tr>
<td>(a) Infection Control Program</td>
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<tr>
<td>The facility must establish an Infection Control Program under which it</td>
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<td>(1) Investigates, controls, and prevents infections in the facility;</td>
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<tr>
<td>(3) Maintains a record of incidents and corrective actions related to infections.</td>
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<tr>
<td>(b) Preventing Spread of Infection</td>
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<tr>
<td>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</td>
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<tr>
<td>(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.</td>
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<tr>
<td>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</td>
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<tr>
<td>(c) Linens</td>
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<tr>
<td>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</td>
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This **REQUIREMENT** is not met as evidenced by:

Based on policy review, observation and interview, it was determined 1 of 2 (Nurse #9) nurses failed to maintain infection control practices to prevent the possible

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<tr>
<th>ID</th>
<th>PREFIX</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tr>
<td>F 441</td>
<td></td>
<td></td>
<td>Prevention of Infection</td>
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<tr>
<td>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</td>
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<tr>
<td>(2) Signature HealthCare at St. Peter Villa continues to 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.</td>
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<tr>
<td>(3) Signature HealthCare at St. Peter requires staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</td>
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Immediate Interventions:
1. Nurse #9 in-serviced by nurse manager/staff development coordinator on appropriate hand washing prior to applying gloves during medication administration and glucometer usage by nurse manager on 3/29/12.

Measures to prevent reoccurrence:
2. 100% all nurses in-serviced by staff development coordinator or on appropriate glucometer cleaning procedure with bleach wipes and frequency by 4/12/12, with return demonstration weekly for four weeks, monthly, then every three months by staff development coordinator/designee.

3. 100% licensed nurses in-serviced staff development coordinator/designee on proper hand washing procedure prior to applying gloves with return demonstration by 4/12/12, and will be completed in orientation, monthly and every three months.

Monitoring:
4. 100% of all nurses are to be monitored monthly during med pass by staff development coordinator or designee, pharmacy for compliance with hand washing and cleaning of glucometers. All variances are to be corrected immediately, staff in-service and reported to DON and administrator, with reports to QA monthly for input and recommendations effective 4/12/12.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION A. BUILDING</th>
<th>(X3) DATE SURVEY COMPLETED:</th>
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<tbody>
<tr>
<td>445139</td>
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**NAME OF PROVIDER OR SUPPLIER**

SIGNATURE HEALTHCARE AT ST PETER VILLA

**STREET ADDRESS, CITY, STATE, ZIP CODE**

141 N McLean
MEMPHIS, TN 38104

<table>
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<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>
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<tbody>
<tr>
<td>F 441</td>
<td>Continued From page 35 cross-contamination between residents by not cleaning a glucometer and failing to wash hands during medication pass observations. The findings included: Review of the facility's &quot;GLUCOMETER - CLEANING OF EQUIPMENT IN PERSONAL CONTACT&quot; policy documented, &quot;...disinfect the exterior surfaces after each use using a cloth or wipe with either an EPA [Environmental Protection Agency] - registered detergent / germicide with a tetracyclolidal or HBV [Hepatitis] / HIV [Human Immunodeficiency Virus] label claim, or a dilute bleach solution of 1: [to] 10 to 1:100 concentration... Wipe dry or allow to air dry between cleaning and between each patient... Disposable professional grade wipes with a short &quot;kill time&quot; ...are the recommended method of disinfection.&quot; Review of the facility's &quot;HANDWASHING&quot; policy documented, &quot;...PURPOSE... To decrease the risk of transmission of infection by appropriate and [hand] washing... POLICY: Handwashing is generally considered the most important single procedure for preventing nosocomial infections... Always wash hands and other skin surfaces immediately and thoroughly after contamination with blood or bodily fluids. Wash hands after removing gloves and in situations where there is visible contamination...&quot; Observations during medication administration on the 200 hall on 3/26/12 at 4:10 PM, Nurse #9 entered room 211A, donned gloves, and obtained an accu-check on this resident. Nurse #9 removed her gloves, entered room 214B, donned...</td>
<td>F 441</td>
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Continued from page 35

gloves and obtained an accu-check on this resident. Nurse #9 removed gloves, and cleansed the glucometer with an alcohol prep. Nurse #9 then entered room 214A, donned gloves and obtained an accu-check on this resident. Nurse #9 placed the glucometer on the medication cart and removed gloves. Nurse #9 did not wash her hands after removing her gloves, and cleansed the glucometer once with only alcohol between 3 residents.

During an interview on the 200 hall on 3/26/12 at 4:25 PM, Nurse #9 was asked when do you clean the glucometer? Nurse #9 stated, "At the start of the shift, then through the night usually." Nurse #9 was asked when do you wash your hands? Nurse #9 stated, "Before I start my med [medication] pass. I use sanitizer between patients if I touch them. That was my third time, I should be washing now." I didn't use the sanitizer after each one. I sure didn't."

The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

This REQUIREMENT is not met as evidenced by:

Based on policy review, observation and interview, it was determined the facility failed to ensure essential equipment was being maintained in a safe operating condition by allowing the dish machine to operate at non recommended temperatures.

Signature Healthcare at St Peter Villa will continue to maintain all essential mechanical, electrical and patient care equipment in safe operating condition.

Immediate interventions:
1. The dish wash machine was turned off and reset by dietary staff. Ecolab and maintenance was notified upon identifying the concern. All dishes were re-washed at the proper temperature to ensure dishes were properly sanitized and verified by the certified dietary manager 3/25/12. Dish machine magnet was replaced by Ecolab 3/26/12.
F 456
Continued From page 37

The findings included:

Review the facility’s "DISHMACHINE
PROCEDURE" policy documented, "...12. If dish
machine temperature is lower than 160 degrees [Fahrenheit (F)] wash or 180 degrees [F] rinse,
turn machine off, call maintenance, and contact
[Named Provider] to correct before washing any
more dishes..."

Review of the facility’s "Dishwasher
Temperature/Chemical Record" for February
2012 revealed, breakfast wash temperature was
140 degrees F on 2/7/12, and the rinse
temperature for lunch was 179 degrees F on
2/9/12, 178 degrees F on 2/15/12 and 179
degrees F on 2/20/12.

Observations in the dish room on 3/25/12 at 9:50
AM, revealed the dish machine in use with a
wash temperature of 150 degrees F and the rinse
temperature of 165 degrees F. Dietary Worker
#1 (washing dishes) was shown the current
temperatures of the machine but continued on
doing the dishes.

During an interview in the dish room on 3/25/12 at
10:00 AM, Dietary Worker #1 was asked about
the dish machine temperatures. Dietary Worker
#1 verified the correct temperatures per the
machine recommendations.

During an interview in the conference room on
3/25/12 at 10:50 AM, the Dietary Manager verified
the dish machine recommendations, and stated,
"...will call [Named Provider]..."
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
SIGNATURE HEALTHCARE AT ST PETER VILLA

**STREET ADDRESS, CITY, STATE, ZIP CODE**
141 N MCLEAN
MEMPHIS, TN 38104

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<td>F 514</td>
<td>Continued From page 38 LE</td>
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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 accurate medical records for wound care for 1 of 16 (Resident #5) sampled residents reviewed of the 40 residents included in the Stage 2 review.

The findings included:
Medical record review for Resident #5 documented an admission date of 12/01/10 with diagnoses of Coronary Artery Disease, Adult Failure to Thrive, Hypertension, Congestive Heart Failure and Schizophrenia. Review of a physician's order dated 3/13/12 documented, "...Cleanse plantar aspect of left foot with wound cleanser, apply salve, cover with dry dressing daily."

Observations in Resident #5's room on 3/25/12 at

<table>
<thead>
<tr>
<th>(X7) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
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<tr>
<td>445139</td>
<td>A BUILDING</td>
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<td></td>
<td>B. WING</td>
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<tr>
<th>(X3) DATE SURVEY COMPLETED</th>
<th>(X5) COMPLETION DATE</th>
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<td>03/28/2012</td>
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**ID TAG**

**PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)**

F 514

Signature Healthcare at St. Peter Villa will continue to 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 contains sufficient information to identify the resident, a record of the resident's assessments, the plan of care, services provided, the results of any preadmission screening conducted by the State and progress notes.

Immediate Interventions:
1. Treatment nurse immediately corrected the order for resident #5, 3/28/12.

Identification of the residents with potential to be affected:
2. Treatment nurse audited all residents with treatments for accuracy of site completed by 3/30/12 with no variances noted and reported to DON and administrator.

Measures to prevent recurrences:
3. Treatment nurse in-serviced by director of nursing on correctly documenting site/location 3/28/12, monthly and pm.
4. 100% nurses in-serviced by staff development coordinator/designee on correctly documenting wound sites/location by 4/12/12 in orientation, monthly and pm.

Monitoring:
5. Weekly auditing of all treatment orders by nursing management for accuracy of site/location with variances corrected, findings to DON and administrator immediately and QA monthly for input and recommendations effective 3/30/12.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/ SUPPLIER/CLA IDENTIFICATION NUMBER:
445139

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
03/28/2012

NAME OF PROVIDER OR SUPPLIER:
SIGNATURE HEALTHCARE AT ST PETER VILLA

STREET ADDRESS, CITY, STATE, ZIP CODE
141 N MCLEAN
MEMPHIS, TN 38104

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 514
Continued From page 39
3:23 PM, revealed Resident #5 lying on her right side in the bed with a dressing on the her right foot and a heel boot on her right foot.

Observations in Resident #5's room on 3/27/12 at 10:25 AM, revealed Nurse #4 performed a dressing change to the resident's right foot.

During an interview in the 4th floor hallway on 3/28/12 at 11:05 AM, Nurse #4 was asked if there was an order for the wound treatment for Resident #5. Nurse #4 reviewed the orders and stated, "...left, right, left, right. It's the right foot. I need to fix that order..."

During an interview in the Director of Nursing's (DON) office on 3/28/12 at 11:25 AM, the DON was asked if there was a current order for the wound treatment for Resident #5. The DON reviewed the orders and wound assessment notes and stated, "Wrong foot, I'll need to correct that."