<table>
<thead>
<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
</table>
| F 278 SS=D | **483.20(g) - (J) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED**  
The assessment must accurately reflect the resident's status.  
A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  
A registered nurse must sign and certify that the assessment is completed.  
Each individual who completes a portion of the 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 and interview, it was determined the facility failed to accurately complete the Minimum Data Set (MDS) to reflect the status of falls, oxygen (O2) therapy and/or pressure ulcers for 4 of 27 (Residents #4, 6, 12 | F 278 | **483.20(g) - (J) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED**  
1. The facility will accurately complete the MDS to reflect the status of falls, oxygen therapy and/or pressure ulcers.  
2. The MDS for resident #4 dated 4/13/11 was corrected to reflect a fall. The MDS for 7/7/11 was corrected to reflect no fall.  
3. The MDS for resident #4 dated 6/15/11 was corrected to reflect a worsening Stage 2 ulcer and the ulcer on the right great toe was documented on the MDS.  
4. The MDS for resident #6 was updated to reflect a fall on 12/10/10.  
5. The MDS for resident #12 was updated to reflect the fall on 5/9/11.  
6. The MDS for resident #21 was updated on 8/25/11 to reflect O2 (oxygen) use.  
7. All nurses were in-serviced on 8/29/11 on documentation by a consultant pharmacist. |
Continued From page 1 and 21) sampled residents.

The findings included:

1. Medical record review for Resident #4 documented an admission date of 12/23/10 with a readmission date of 7/8/11 with diagnoses of Diabetes, Hypertension, Dementia with Delusions, Bipolar Disease and Diabetic Neuropathy. The nurses notes dated 4/7/11 documented Resident #4 had a fall without injury. A significant change MDS dated 4/13/11 for Resident #4 documented “Section J... J1800. Any Falls Since Admission or Prior Assessment” had no falls documented. A significant change MDS dated 7/17/11 for Resident #4 in “Section J... J1800...” documented yes for a fall. The 4/13/11 MDS and the 7/17/11 MDS were inaccurate for falls.

During an interview in the MDS office on 8/17/11 at 9:00 AM, Nurse #11 confirmed that the 4/13/11 MDS should have documented one fall with no injury and the 7/17/11 MDS should have documented no falls.

Review of the "WEEKLY PRESSURE ULCER RECORD" dated 7/8/11 documented, "...DATE OF ONSET: 07-06-11 SITE/LOCATION: R [right] buttock... STAGE...III...". Review of the "WEEKLY PRESSURE ULCER RECORD" dated 7/7/11 documented, "...DATE OF ONSET: 07-06-11 SITE/LOCATION: R great toe tip... STAGE...U [unstageable]... Stable dry eschar...". The significant change MDS dated 7/17/11 documented, "...Section M...M0303... Number of Stage 2 pressure ulcers...1...Number of Stage 3 pressure ulcers...1...Unstageable - Slough and/or
**F 278** Continued From page 2

The 7/17/11 MDS was inaccurate for pressure ulcers.

During an interview on the first floor hall on 8/17/11 at 3:00 PM, Nurse #14 was asked about Resident #4's pressure ulcers. Nurse #14 confirmed that the Stage 2 and Stage 3 were the same ulcer. Nurse #14 stated, Resident #4 was readmitted on 6/15/11 with a Stage 2 right buttock ulcer after hospitalization and at the time of the most current readmission of 7/8/11 the same ulcer was restaged as Stage 3.

During an interview in the MDS office on 8/17/11 at 3:00 AM, Nurse #11 confirmed that the Stage 3 pressure ulcer should have been documented as a worsening Stage 2 and that the right great toe pressure should have been documented on the MDS.

2. Medical record review for Resident #6 documented an admission date of 6/5/97 with a readmission date of 6/30/11 with the diagnoses of Dementia, Seizures, Cardiovascular Disease, Depression and Cardiovascular Disease. Review of an "INCIDENT/ACCIDENT REPORT" dated 8/8/10 documented a fall. The fall was not noted on the annual MDS dated 12/14/10.

During an interview in the MDS office on 8/16/11 at 1:30 PM, Nurse #10 confirmed the MDS did not reflect that Resident #6 had a fall.

3. Medical record review for Resident #12 documented an admission date of 11/16/01 with diagnoses of Paranoid Schizophrenia, Convulsions, Senile Depressive Disorder and Rheumatoid Arthritis. Review of the nurses notes...
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/EMPLOYER IDENTIFICATION NUMBER:
445185

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
08/17/2011

NAME OF PROVIDER OR SUPPLIER
HIGHLANDS OF MEMPHIS HEALTH & REHAB

STREET ADDRESS, CITY, STATE, ZIP CODE
3549 NORRISWOOD
MEMPHIS, TN 38111

(X4) ID PREFIX TAG

(X5) COMPLETION DATE

F 278 Continued From page 3
dated 3/17/11 and 5/19/11 documented Resident
#12 had a fall on these dates. Review of the
annual MDS dated 7/17/11 documented,
"...Section J...1800. Any Falls Since Admission
or Prior Assessment...0..."

During an interview at the first floor nurses'
station on 8/17/11 at 8:10 AM, Nurse #10
confirmed the 5/19/11 fall should have been
added to the 7/17/11 MDS.

4. Medical record review for Resident #21
documented an admission date of 10/22/10 with a
readmission date of 2/7/11 with diagnoses of
Chronic Obstructive Pulmonary Disease,
Hypertension and Atrial Fibrillation. Review of a
physician's order dated 7/12/11 documented,
"...C2 @ [at] 1-[to] 2L [illers] BNC [bivnasal
cannula]..." Review of the MDS dated 7/26/11
documented Resident #21 was not coded as
receiving O2 therapy.

During an interview in the MDS office on 8/17/11
at 9:10 AM, Nurse #10 confirmed the MDS did
not reflect that Resident #21 was receiving O2.

F 280 SS=O
483.20(d)(3), 483.10(k)(2) RIGHT TO
PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged
incompetent or otherwise found to be
incapacitated under the laws of the State, to
participate in planning care and treatment or
changes in care and treatment.

A comprehensive care plan must be developed
within 7 days after the completion of the
comprehensive assessment; prepared by an
interdisciplinary team, that includes the attending
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CIA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION A. BUILDING</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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</thead>
<tbody>
<tr>
<td>445165</td>
<td>B. WING</td>
<td>08/17/2011</td>
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</table>

NAME OF PROVIDER OR SUPPLIER:
HIGHLANDS OF MEMPHIS HEALTH & REHAB

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<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 280</td>
<td>Continued From page 4 physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</td>
<td>F 280</td>
<td>3. The Unit Managers and ADON will monitor the care plan documentation weekly and PRN and will report findings to the DON. 4. The DON will report findings to the QA Committee until compliance is achieved.</td>
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</table>

Completion Date
09-02-2011

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 care plan was revised to reflect interventions for oxygen therapy for 1 of 27 (Resident #20) sampled residents.

The findings included:

Medical record review for Resident #20 documented an admission date of 12/26/07 with a readmission date of 6/8/11 with diagnoses of Congestive Heart Failure, Hypertension, Alzheimer's, Cardiomyopathy, Coronary Artery Disease, Cerebrovascular Accident with Left Side Hemiplegia and Urinary Tract Infection. Review of the physician's orders dated 7/8/11 documented, "...O2 [oxygen] @ [at] 2L [liters] BNC [binaural cannula] CONTINUS [continuous]." The current care plan was not revised to reflect that Resident #20 was receiving O2 therapy.

Observations in Resident #20's room on 8/15/11 at 4:55 AM, on 8/16/11 at 4:35 PM and on 8/17/11 at 7:50 AM, revealed Resident #20 was
F 280 Continued From page 5 receiving O2 BNC at 3L.

During an interview in the Minimum Data Set office on 8/17/11 at 9:10 AM, Nurse #10 stated, "...I don't know why O2 was not on there [care plan]..."

F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

SS=D 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to follow the physician's orders for rechecking elevated blood sugars, obtaining a blood pressure and pulse prior to medication administration and administering correct insulin dosage per sliding scale for 1 of 27 (Resident #10) sampled residents.

The findings included:

Medical record review for Resident #10 documented an admission date of 11/3/09 with diagnoses of Diabetes Mellitus, Morbid Obesity, Hypertension, Chronic Obstructive Pulmonary Disease and Presenile Dementia. Review of the physician's orders for 6/1/10 through 6/30/10, signed and dated by the physician on 5/31/10.

Completion Date 09-02-2011
<table>
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<tr>
<th>ID TAG</th>
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<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 309</td>
<td>Continued From page 6 documented recheck accuchecks if blood sugar greater than 401.</td>
<td>F 309</td>
<td>While on page 6 documented recheck accuchecks if blood sugar greater than 401.</td>
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<td>Review of the June 2010 and July 2010 MAR documented the following:</td>
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<td></td>
<td>a. 6/10/10 accucheck blood sugar of 444 with no recheck.</td>
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<td>b. 6/26/10 accucheck blood sugar of 420 with no recheck.</td>
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<td>c. 7/8/10 accucheck blood sugar of 430 with no recheck.</td>
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<td>During an interview in the administrative office on 8/17/11 at 10:30 AM, the Director of Nursing</td>
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<td>confirmed no blood sugar rechecks were done on 6/10/10, 6/26/10 and 7/8/10.</td>
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<td>Further review of the physician's orders dated 7/21/11 documented, &quot;...ACCUECHECKS TWICE DAILY... LISINOPRIL 20 MG [milligrams] TABLET... BY MOUTH EVERYDAY HOLD IF SBP [systolic blood pressure] &lt; [less than] 110 OR HR [heart rate] &lt; 60... NOVOLIN R 100 U [units]/[per] ML [milliliter] UNIT; [accucheck results of] 151- [to] 200 = [amount of insulin to be administered] 2 UNITS: 201-250 = 4 UNITS...&quot;</td>
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<td>Records (MAR) documented the following:</td>
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<td></td>
<td>a. 3/15/11 accucheck blood sugar 159 with no insulin given - correct dose 2 units.</td>
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<td></td>
<td>b. 5/1/11 accucheck blood sugar 159 with no insulin given - correct dose 2 units.</td>
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<td>c. 5/15/11 accucheck blood sugar 233 with 6 units of Novolin R insulin given - correct dose 4 units.</td>
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<td>ID</td>
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<td>SUMMARY STATEMENT OF DEFICIENCIES</td>
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<td>F 309</td>
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<td>F 308</td>
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<td>d. 5/28/11 accuchek blood sugar 167 with no insulin given - correct dose 2 units.</td>
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<td>e. Lisinopril was given 3/11/11 through (-) 3/31/11, 5/1/11-5/31/11, 6/1/11-6/30/11 and, 7/1/11-7/31/11 without a blood pressure (BP) or HR being taken prior administering Lisinopril.</td>
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<td>During an interview at the second floor nurses' station on 8/17/11 at 8:30 AM, Nurse #12 confirmed there were incorrect doses of insulin given and no blood pressure and heart rate prior to administering Lisinopril as ordered.</td>
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<tr>
<td>F 315</td>
<td>SS=D</td>
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<td>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</td>
<td>F 315</td>
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<td>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 is 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.</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on review of &quot;Long-Term Pocket Guide for Infection Control,&quot; medical record review and observation, it was determined the facility failed to ensure perineal care was performed according to guidelines for 1 of 4 (Resident #11) sampled residents observed receiving perineal care. The findings included:</td>
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**Completion Date:** 09-02-2011
<table>
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<tr>
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<tr>
<td>F 315</td>
<td>Continued From page 8 Review of the &quot;Long-Term Pocket Guide for Infection Control&quot;, section 2, page 50 documented...</td>
<td>F 315</td>
<td>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</td>
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<tr>
<td>322</td>
<td>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</td>
<td>322</td>
<td>F322 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</td>
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Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

This REQUIREMENT is not met as evidenced by:

1. The facility will ensure that a resident who is fed by naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities and naso-pharyngeal ulcers and restore, if possible, normal eating.
Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure staff flushed Peritoneal Endoscopic Gastrostomy (PEG) tubes with the prescribed amount of water (H2O) prior to the administration of medications and/or allowed medications to flow per gravity for 1 of 1 (Resident #2) sampled resident and 1 of 2 Random Resident (RR) #1 with a PEG tube.

The findings included:

1. Review of the facility's "ENTERAL TUBE MEDICATION ADMINISTRATION POLICY AND PROCEDURE" documented, "...Flush tube with 30cc [cubic centimeter] before and after administration of medication..."

2. Medical record review for Resident #2 documented an admission date of 12/9/09 with diagnoses of Hypertension, Late Effect Cerebral Vascular Disease, Chronic Kidney Disease and Gastrostomy Status. Review of a physician's order dated 7/20/11 documented, "...WATER 30CC BOLUS FLUSH BEFORE AND AFTER MEDICATION ADMINISTRATION..."

Observations in Resident #2's room on 8/15/11 at 7:25 AM, revealed Nurse #3 administered medications per PEG to Resident #2. Nurse #3 did not allow the medications to flow per gravity and flushed with 20cc's of H2O after the medications were administered.


2. The nurse #3 for resident #2 was in-serviced on PEG tube feedings on 8/18/11 by the DON.
3. The nurse #2 for RR #1 was in-serviced on PEG tube feedings on 8/18/11 by the DON.
4. All nurses were in-serviced on PEG tube feedings on 8/29/11 by consultant pharmacist.
5. Unit Managers will monitor one (1) tube feeding a week until compliance is achieved and report to the DON weekly.
6. The DON will report to the QA Committee until compliance is achieved.
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<td>F 322</td>
<td>Continued From page 10</td>
<td>Observations in RR #1's room on 8/15/11 at 5:20 AM, revealed Nurse #2 flushed RR #1's PEG tube with 10cc's of H2O, administered the medication and flushed with 10cc's of H2O.</td>
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<td>F 323</td>
<td>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</td>
<td>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</td>
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This REQUIREMENT is not met as evidenced by:
Based on policy review, review of investigative report, medical record review, observation and interview, it was determined the facility failed to ensure a new intervention was implemented after each fall for 2 of 8 (Residents #9 and 12) sampled residents identified with falls.

The findings included:
1. Review of the facility's "Accidents and Supervision" policy documented, "...3. Implementation of interventions-using specific interventions to try to reduce a resident's risk
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continued from page 11

from hazards in the environment. The process includes...

d. Documenting interventions (...plans for action developed by the Quality Assurance Committee of care plans for individual resident)

e. Ensuring that the interventions are put into action... i. Resident-directed approaches may include: i. implementing specific interventions as part of the plan of care... ii. facility records document the implementation of these interventions... 4.c. Modifying or replacing interventions as needed."

2. Medical record review for Resident #9 documented an admission date of 6/4/09 with diagnoses of Anxiety Disorder, Hypertension, Scoliosis, Depressive Disorder and Polyarthritics.

Review of the care plan dated 5/16/11 documented, "...Risk for falls secondary to decreased mobility R/T [related to] severe arthritis & [and] chronic pain with hx [history] of falls. Resident had fall on 5/13/2011,... Help resident to toilet in am and after meals at hs [bedtime] and prn [as needed]." Review of the nurses notes dated 5/25/11 at 4:00 AM documented, "...Resident observed sitting on mat at bedside. Resident complains of left face and back pain..."

Review of the investigative report dated 5/25/11 documented, "...Staff to toilet resident upon rising, during rounds, PRN [as needed], @ [at] HS when awake..." The facility failed to modify or add new interventions to reduce the risk of falls after the resident sustained a fall on 5/25/11.

3. Medical record review for Resident #12 documented an admission date of 11/16/01 with diagnosis of Paranoid Schizophrenia, Convulsions, Senile Depressive Disorder and...
F 323 Continued From page 12

Rheumatoid Arthritis. Review of a physician's order dated 3/17/11 documented, "...alert male while up in wheelchair..." Review of the physician's orders dated 7/14/11 documented no order for the alert male. Review of the comprehensive care plan dated 4/6/11 and updated 7/18/11 documented, "...Potential for falls related to her RA [rheumatoid arthritis]; resident had a fall on 03/16/11... Ensure alert male is on w/c [wheelchair] while up..." Review of the nurses notes dated 3/17/11 and 5/19/11 documented Resident #12 had a fall on these dates. Review of the annual Minimum Data Set (MDS) dated 7/17/11 documented, "...Section J....J1600. Any Falls Since Admission or Prior Assessment...0..." The facility failed to implement the 3/17/11 alert male intervention and failed to document a new intervention for the 5/19/11 fall.

Observations in Resident #12's room on 8/16/11 at 7:15 AM, revealed Resident #12 seated in a w/c with no alert male in place.

Observations in the 100 hall on 8/16/11 at 11:30 AM, revealed Resident #12 seated in a w/c with no alert male in place.

Observations in the first floor dining room on 8/17/11 at 7:40 AM, revealed Resident #12 seated in a w/c with no alert male in place.

During an interview on the first floor hall on 8/17/11 at 7:50 AM, Nurse #5 was asked if Resident #12 had an alert male. Nurse #5 stated, "No..."

During an interview at the first floor nurses' station on 8/17/11 at 8:10 AM, Nurse #10
<table>
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<tr>
<th>F 323</th>
<th>Continued From page 13</th>
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<tbody>
<tr>
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<td>confirmed the 5/19/11 fall should have been added to the 7/17/11 MDS. Nurse #10 was asked about interventions for the 5/19/11 fall. Nurse #10 confirmed there were no new interventions on the care plan after the 5/19/11 fall.</td>
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<table>
<thead>
<tr>
<th>F 328</th>
<th>483.3(k) TREATMENT/CARE FOR SPECIAL NEEDS</th>
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<tbody>
<tr>
<td></td>
<td>The facility must ensure that residents receive proper treatment and care for the following special services:</td>
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<td>Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</td>
</tr>
</tbody>
</table>

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 obtain a physician's order for oxygen (O2) and failed to ensure O2 was administered in accordance with the physician's order for 2 of 8 (Residents #10 and 20) sampled residents receiving oxygen.
### Summary Statement of Deficiencies

**445165**

**Highlands of Memphis Health & Rehab**

<table>
<thead>
<tr>
<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>
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</table>
| F 328         | Continued From page 14
The findings included:

1. Review of the facility's "Guide to Oxygen Delivery Systems" policy documented, "...Never administer oxygen by nasal cannula at more than 2 L [liters] / [per minute] [M] to a patient with chronic lung disease unless you have a specific order to do so..."

2. Medical record review for Resident #10 documented an admission date of 11/3/09 with diagnoses of Diabetes Mellitus, Morbid Obesity, Hypertension, Chronic Obstructive Pulmonary Disease and Presenile Dementia. Review of the physician's orders dated 7/21/11 did not include an order for O2 therapy.

Observations in Resident #10's room on 8/15/11 at 8:25 AM and 11:50 AM, revealed Resident #10 receiving O2 at 2 L/M per nasal cannula (BNC).

Observations in Resident #10's room on 8/16/11 at 7:15 AM, 9:30 AM and 2:30 PM, revealed Resident #10 receiving O2 at 3 L/M per BNC.

During an interview at the second floor nurses' station on 8/17/11 at 8:30 AM, Nurse #12 confirmed Resident #10's current orders dated 7/21/11 did not include an order for O2 therapy.

3. Medical record review for Resident #20 documented an admission date of 12/28/07 and a readmission date of 6/8/11 with diagnoses of Congestive Heart Failure, Hypertension, Alzheimer's, Cardiomyopathy, Coronary Artery Disease and Cerebrovascular Accident with Left Sided Hemiplegia. Review of the physician's orders dated 7/8/11 documented, "...O2 @ 2L..."
Continued From page 15
BNC CONTINOUS [continuous]...

Observations in Resident #20's room on 8/15/11 at 4:50 AM, on 8/16/11 at 4:35 PM and on 8/17/11 at 7:50 PM, revealed Resident #20 receiving O2 at 3L/M BNC.

During an interview at the porch nurses' station on 8/17/11 at 1:00 PM, Nurse #6 confirmed the oxygen rate for Resident #20 was to be at 2L/M BNC per physician's order.

F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

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

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

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if
F 441 Continued From page 16

direct contact will transmit the disease.
(3) The facility must require staff to wash their
hands after each direct resident contact for which
hand washing is indicated by accepted
professional practice.

c) Linens
Personnel must handle, store, process and
transport linens so as to prevent the spread of
infection.

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 ensure 1 of 1 (Nurse #2) nurse
performed a sterile procedure for tracheotomy
(trach) care to prevent the potential spread of
infection.

The findings included:

Review of the facility's "Tracheotomy Care and
Cleaning" policy documented, "...This is a
STERILE procedure... 5. Wash hands prior to
beginning procedure... 8. Set up sterile field. 9.
Pour necessary solutions into sterile containers.
10. Put on sterile glove... 12. Remove soiled
tracheostomy dressing and drop into the plastic
discard bag along with the single soiled glove. 13.
Put on sterile pair of gloves. 14. Clean the skin
around the tube using gauze pads or cotton tip
applicator soaked in peroxide and sterile water..."

Medical record review for Random Resident (RR)
#1 documented an admission date of 4/4/11 with
**F 441** Continued From page 17

diagnoses of Dysphagia, Diabetes Mellitus, Tracheotomy and Chronic Obstructive Bronchitis. Review of a physician’s order dated 7/20/11 documented, "...TRACH CARE EVERY SHIFT..."

Observations in RR #1’s room on 7/15/11 at 5:20 AM, Nurse #2 administered medications to RR #1 per Percutaneous Endoscopy Gastrostomy tube. After administering the medications Nurse #2 removed her gloves, opened the trach care kit, then removed a pair of gloves and scissors from her uniform pocket. Nurse #2 used her scissors to cut open the packet with the trach ties. Next Nurse #2 applied a pair of gloves from her uniform pocket, obtained q-tips and bottle of sterile water from the bedside table, she then removed her gloves and applied a pair of sterile gloves and proceeded to suction RR #1’s trach. Nurse #2 then changed the trach ties and cleaned around the trach with a q-tip and water. After cleaning around the trach Nurse #2 removed her gloves, applied a pair of sterile gloves and suctioned RR #1’s trach.

During an interview in the Director of Nursing’s (DON) office on 9/17/11 at 7:50 AM, the DON stated, "They are to wash hands before doing a sterile procedure..."

**F 514**

483.75()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.

**F 514**

483.75()1 RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

SS=D

1. The facility will maintain medical records that are complete and accurate by reconciling physician’s orders and will document administration of medications as ordered by the physician.
F 514 Continued From page 18

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 policy review, medical record review and interview, it was determined that the facility failed to maintain medical records that were complete and accurate by not reconciling physician's orders and failed to document administration of medications as ordered by the physician for 2 of 27 (Residents #10 and #12) sampled residents.

The findings included:

1. Medical record review for Resident #10 documented an admission date of 11/3/09 with diagnoses of Diabetes Mellitus, Morbid Obesity, Hypertension, Chronic Obstructive Pulmonary Disease and Pseudopel Dementia. Review of the current physician's orders dated 7/21/11 documented, "...[start date] 9/9/10...

ACCUCHECKS TWICE DAILY... [start date] 3/1/11...RISERDAL 0.5MG [milligrams]

TABLET... 1 TAB [tablet] BY MOUTH EVERYDAY 6PM... [start date] 4/15/11...

TRAZADONE 50 MG TABLET 1 TAB BY MOUTH AT BEDTIME... [start date] 9/9/10...

LANTUS 100UN [units]/[per] 1 ML [milliliter]

INSULIN 42 UNITS SUB-Q [subcutaneous]

EVERY MORNING... [start date] 9/9/10...

LANTUS 100UN/ML INSULIN 56 UNITS SUB-Q EVERY EVENING..."
Review of the May 2011, June 2011 and July 2011 Medication Administration Records (MAR) revealed the following medications and accucheks were not documented:

- a. Lantus 56 units at 6:00 PM, Trazadone 50 mg 9:00 PM and Risperdal 0.5 mg at 6:00 PM on 5/20/11.
- b. Lantus 56 units at 5:00 PM on 5/22/11.
- c. Accucheks at 7:00 AM on 6/7/11, 6/8/11 and 6/12/11.
- d. Trazadone 50 mg at 9:00 PM and Risperdal 0.5 mg at 6:00 PM on 6/20/11.
- e. Lantus 55 units at 5:00 PM on 7/15/11 and 7/22/11.
- f. Lantus 42 units at 7:00 AM on 7/24/11.
- g. Trazadone 50 mg at 9:00 PM on 7/20/11.

During an interview at the second floor nurses' station on 8/17/11 at 9:30 AM, Nurse #12 confirmed the medications and accucheks were not documented.

2. Review of the facility's "RECAPITULATION OF COMPUTERIZED PHARMACY RECORDS" policy documented, "...Corrections, additions, and changes to the computerized medical record should be made by a licensed nurse, Facility medical records staff, or an authorized designee... Facility should maintain any further changes in physician orders in the current medical record and the computerized medical record..."

Medical record review for Resident #12 documented an admission date of 11/16/01 with diagnoses of Paranoid Schizophrenia, Convulsions, Senile Depressive Disorder and
**NAME OF PROVIDER OR SUPPLIER**
HIGHLANDS OF MEMPHIS HEALTH & REHAB

**STREET ADDRESS, CITY, STATE, ZIP CODE**
3549 NORRISWOOD
MEMPHIS, TN 38111

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 514</td>
<td>Continued From page 20 Rheumatoid Arthritis. Review of a physician's order dated 3/17/11 documented, &quot;...alert mate while up in wheelchair...&quot; The physician's order dated 7/14/11 did not include an order for the alert mate. The comprehensive care plan dated 4/6/11 and updated 7/18/11 documented, &quot;...Ensure alert mate is on w/c [wheelchair] while up...&quot; Observations in Resident #12's room on 8/16/11 at 7:15 AM, revealed Resident #12 seated in a w/c with no alert mate in place. Observations in the 100 hall on 8/16/11 at 11:30 AM, revealed Resident #12 seated in a w/c with no alert mate in place. Observations in the first floor dining room on 8/17/11 at 7:40 AM, revealed Resident #12 seated in a w/c with no alert mate in place. During an interview on the 100 hall on 8/17/11 at 7:50 AM, Nurse #6 was asked if Resident #12 had an alert mate. Nurse #6 stated, &quot;No...&quot; During an interview at the first floor nurses' station on 8/17/11 at 8:25 AM, Nurse #13 was asked about the alert mate not being on the current orders. Nurse #13 confirmed the alert mate should have been on the current 7/14/11 orders.</td>
<td>F 514</td>
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