STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/APPLICANT
IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
04/04/2013

NAME OF PROVIDER OR SUPPLIER

BRIGHT GLADE HEALTH AND REHABILITATION CENTER INC

STREET ADDRESS, CITY, STATE, ZIP CODE
5070 SANDERLIN AVENUE
MEMPHIS, TN 38117

(X4) ID PREFIX TAG

F 164
SS = F

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

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

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

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

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

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

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

This REQUIREMENT is not met as evidenced by:

Based on observation and interview, it was determined the facility failed to ensure there were privacy curtains in 40 of 45 (Rooms #100, 102, 103, 104, 105, 107, 108, 109, 110, 111, 112, 113, 114, 201, 203, 205, 206, 207, 206, 209, 210, 211, 213, 214).

F 164

483.01(e), 483.75(1) (4) personal privacy/confidentiality of records

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

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

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

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

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

RECEIVED
APR 2 2 2013

Laboratory Directors or Provider/Supplier Representative’s Signature:

Title:

Date:

4/19/13

Any deficiency statement ends 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 disclosed 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosed 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.
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| F 164 | Continued From page 1  
212, 213, 214, 215, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313 and 315) resident rooms to provide full visual privacy to each resident.  
The findings included:  
1. Observations on the 100 hall on 4/2/13 beginning at 7:45 AM revealed the following:  
a. Resident rooms 100, 101, 102, 103, 104, 105, 107, 108, 109, 110, 111, 113 and 114 - no privacy curtain between the A bed and the door. The privacy curtain between A and B beds only goes to the foot of the bed and does not fully enclose either bed.  
b. Resident room 112 is a private room with no privacy curtain.  
During an interview in room 104 on 4/4/13 at 2:15 PM, Certified Nursing Assistant (CNA) #1 was asked are there privacy curtains in the room for the back bed. CNA #1 stated, "No ma'am." CNA #1 was then asked if there were privacy curtains in the private rooms. CNA #1 stated, "No ma'am."  
2. Observations on the 200 hall on 4/2/13 beginning at 7:45 AM revealed the following:  
a. Resident rooms 201, 203, 205, 206, 207, 212, 213, 214 and 215 - no privacy curtain between the A bed and the door. The privacy curtain between A and B beds only goes to the foot of the bed and does not fully enclose either bed.  
b. Resident rooms 208, 209, 210 and 211 are private rooms with no privacy curtains.  
3. Observations in the 300 hall on 4/2/13 beginning at 7:45 AM revealed the following:  

Corrective Action:  
1) An in-service for all staff on privacy/privacy curtains was conducted on 4/4/13 by the Administrator and Director of Nursing.  
2) On 4/4/13, the Administrator did a facility audit to recognize the residents that would be affected by the deficient practice. New privacy curtains will be mounted in each room to ensure each resident has full privacy.  
3) Random daily audits though facility rounds to assurance that staff are providing as much privacy with care as can until curtains are installed will be done by department heads.  
4) The O.A. Committee, consisting of Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Staffing Coordinator, Medical Records, Registered Dietician, Social Worker, Maintenance Supervisor, Activities Coordinator, will monitor for compliance through review of facility rounds and documented audits for three months. If compliance is not met, facility staff will be re-in serviced and audits will continue until substantial compliance is met.  
Completed by 6/20/13
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

**BRIGHT GLADE HEALTH AND REHABILITATION CENTER INC**

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

5070 SANDERLIN AVENUE
MEMPHIS, TN 38117

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<tr>
<td>F 164</td>
<td>Continued From page 2</td>
<td>a. Resident rooms 301, 302, 303, 304, 305 and 307 - no privacy curtain between the A bed and the door. The privacy curtain between A and B beds only goes to the foot of the bed and does not fully enclose either bed. b. Resident rooms 306, 308, 309, 310, 311, 312, 313, and 315 are private rooms with no privacy curtains.</td>
<td>F 241</td>
<td>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</td>
<td>SS=D</td>
<td>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</td>
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<td>F 241</td>
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**CorRECTIVE ACTION**

1) Certified Nursing Assistant # 2 was in-served on 4/4/13 on dignity while feeding residents by the Director of Nursing.
2) In-service for all staff on dignity issues was conducted on 4/4/13 and 4/15/13 by the Director of Nursing.
3) Department heads will monitor for compliance with dignity during meals daily.
4) The Q.A. Committee, consisting of Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Staffing Coordinator, Medical Records, Registered Dietitian, Social Worker, Maintenance Supervisor, Activities Coordinator, will monitor for compliance through review of facility rounds and documented audits for three months. If compliance is not met, facility staff will be re-in serviced and audits will continue until substantial compliance is met.

**Completed by 4/15/13**
<table>
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<th>ID Number</th>
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<tr>
<td>F 241</td>
<td>Continued From page 3</td>
<td>During an interview in the Director of Nursing's (DON) office on 4/4/13 at 2:20 PM, the DON was asked what the policy for staff feeding residents is. The DON stated, &quot;Staff should sit at eye level when feeding residents...&quot;</td>
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<tr>
<td>F 272</td>
<td>483.20 (b)(1) COMPREHENSIVE ASSESSMENTS</td>
<td>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.</td>
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F 272 Continued From page 4
Documentation of participation in assessment.

This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review and interview, it was determined the facility failed to accurately assess pressure ulcers for 3 of 5 (Residents #37, 68 and 78) residents identified by the facility having pressure sores of the 32 residents included in the stage 2 review.

The findings included:

1. Review of facility’s “Skin Care Guidelines” policy documented, "...A thorough inspection of the patient’s skin must be accomplished within the first four (4) hours of admission/readmission to the facility. Documentation of findings on the admission note should include any reddened areas... Notification to the... physician must be done timely... Once a pressure ulcer is identified, an assessment must be documented in the Nurses Notes... The Weekly Wound Progress Note (Form4334) must then be initiated by the charge nurse. The Date of Onset and the Location must be documented... Daily wound treatment documentation must be completed on the Treatment Administration Record (TAR)... Pressure ulcers must be assessed and measured at least once a week on the same day of the week... When documenting the size of all wounds, the nurse should include length, width,
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

(X1) PROVIDER/SUPPLIER/Clinical Identification Number: 445426

(X2) MULTIPLE CONSTRUCTION

A BUILDING ______________
B. WING

(X3) DATE SURVEY COMPLETED: 04/04/2013

**NAME OF PROVIDER OR SUPPLIER**

BRIGHT GLADE HEALTH AND REHABILITATION CENTER INC

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

5076 SANDERLIN AVENUE
MEMPHIS, TN  38117

**ID PREFIX TAG**

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION)

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<td>F 272</td>
<td>F 272</td>
<td>The MDS Coordinator and Assistant Director of Nursing completed a 100% review of all current resident charts for accurate MDS assessments and care plans between 4/5/13 to 4/8/13. 3) CNAs were instructed &amp; in-services by the Director of Nursing from 4/3/13 – 4/15/13 on the vital importance of their role in helping to identify &amp; prevent skin ulcers. Charge nurses were instructed similarly regarding their care.</td>
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2. Closed Medical record review for Resident #37 documented an admission date of 10/5/12 with diagnoses history of fall with Fracture Right Hip with Open Reduction Internal Fixation, Atrial Fibrillation, Hypertension, Anemia, Coronary Artery Disease, Parkinson’s Disease, History of Myocardial Infarction, Hypothyroidism and Osteoarthritis. The initial admission nursing assessment dated 10/5/12 documented the resident's skin condition as pink, dry, intact, and "redness to buttocks." The Braden Scale assessment dated 10/5/12 documented the resident at high risk for skin impairment. The initial care plan dated 10/5/12 documented the problem: "skin integrity" with intervention of "preventive care." A physician's order dated 10/7/12 documented, "clean area mid coccyx with NS [normal saline] or wound cleanser, apply Santyl to slough and apply foam and cover qd until healed, Multivitamin with minerals qd, Juven 1 pkg [package] in h2o [water] bid [twice daily] until wound resolved... coccyx ulcer st. [stage] III with slough." The Weekly Wound Progress Form dated 10/7/12 documented the wound as a stage...
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER: BRIGHT GLADE HEALTH AND REHABILITATION CENTER INC

STREET ADDRESS, CITY, STATE, ZIP CODE: 5070 SANDERLIN AVENUE
MEMPHIS, TN 38117

04/04/2013

ID PREFIX TAG: 445426

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

ID PREFIX TAG: F 272

Responsibility to be vigilant and proactive in resident assessment duties each day to assure preventive and appropriate care is being delivered on 4/3/13-4/15/13 by the Director of Nursing and on 4/8/13 and 4/10/14 by the wound care specialist which incorporated skin assessments, treatments, documentation, and preventative measure responsibilities. After a thorough assessment of facility operations by the corporate QA staff it was determined that greater involvement by the nurse management team was needed to strengthen and attain more consistency in the skin care program. The facility has implemented weekly skin audits to record and monitor skin care progress, delivery of treatments and effectiveness which involves nursing staff and management. Intensive in-services have been ongoing and will continue until satisfactory performance is achieved relative to assuring that identification of skin breakdown and corresponding intervention occurs to prevent avoidable skin ulcers and decubitus. Newly hired staff members will receive detailed orientation that will be specifically inclusive of the areas cited to assure newly enacted programs and quality care protocols will be followed.

F 272 Continued from page 6

3 measuring 1.5 by (x) 0.6 x 0.1 centimeters with slough with documentation that the physician was not notified until 10/8/12. There was no documentation that the physician was notified of the redness to the buttocks documented on admission. There was no documentation of any treatments documented per facility policy until 10/7/12 when the pressure sore had deteriorated to a stage 3 with slough.

During an interview on the 100 hall on 4/3/13 at 8:20 AM, Nurse #3 was asked about assessing pressure ulcers. Nurse #3 stated, "We assess, measure, start a wound sheet, get treatment orders and start treatments."

During an interview on the 200 hall on 4/3/13 at 9:00 AM, Nurse #4 was asked about assessing pressure ulcers. Nurse #4 stated, "I would assess the patient, measure the wounds, document it on the wound sheet, get orders and treat the wound. We measure wounds every Friday and document on the wound sheet."

During an interview in the beauty shop on 4/3/13 at 4:20 PM, the Assistant Director of Nursing (ADON), was asked about the 2/7/13 wound care order. The ADON stated, "That is our wound protocol for a stage 3, I wrote that from our wound protocol."

During an interview in the beauty shop on 4/3/13 at 4:30 PM, the ADON stated, "I consider redness as a stage one."

During an interview in the beauty shop on 4/3/13 at 5:15 PM, the ADON stated, "I would have expected a skin protectant to be used on the area..."
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<td>F 272</td>
<td>Continued From page 7 [redness] according to our protocol.</td>
<td>F 272</td>
<td>4) The Q.A. Committee, consisting of Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Staffing Coordinator, Medical Records, Registered Dietician, Social Worker, Maintenance Supervisor, Activities Coordinator will monitor compliance through resident rounds and chart audits weekly for three months. If compliance is not met the facility nursing staff will be re-inserviced and audits will continue until substantial compliance is met. Different members of the committee will participate depending on the nature of the audit. Random audits by the Clinical Billing and Research Consultant will be conducted for the next three months to assure the accuracy of the reports and to improve patient safety and skin integrity. Completed by 4/20/13</td>
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<td>During an interview in the beauty shop on 4/3/13 at 5:45 PM, the Director of Nursing (DON) was asked what should be done when redness is recognized on a resident. The DON stated, &quot;Yes I would have expected the nurse to notify the MD [Medical Doctor] of the redness. I do consider that redness a stage one and there should have been a treatment put in place.&quot;</td>
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<td>3. Medical Record review for Resident #68 documented an admission date of 12/31/12 with diagnoses of Deep Vein Thrombosis, Muscle Weakness, Rehabilitation Process, Symbolic Dysfunction, Senile Dementia, Chronic Airway Obstruction, Bladder Cancer, Spinal Stenosis, Flu, Esophageal Reflux, Bladder Cancer, Constipation, Vitamin D Deficiency and Pneumonia. Review of a physician's order dated 1/30/13 documented, &quot;...Cleanse left outer (L) [left] foot near toe c [with] NS or wet cleanser. Apply Hydrogel gauze/ointment. Change daily...&quot;</td>
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<td>Review of a Clinical Notes documented the following:</td>
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<td>a. 1/29/13 - &quot;...Noted that he has a open area on the left out [outer] heel... New order to treat the heel wound and heel were placed [placed] on pillow...&quot;</td>
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<td>b. 2/18/13 - &quot;...Slough noted during treatment to L outer toe...&quot;</td>
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<td>c. 2/20/13 - &quot;...Pt [patient] with Stage II PrU [pressure ulcer] noted to L outer foot...&quot;</td>
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<td>d. 3/17/13 - &quot;...His left side of foot has ulcer that receives daily dressing. Still has some slough present...&quot;</td>
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<td>e. 3/20/13 - &quot;...redressed the wound to the right...&quot;</td>
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BRIGHT GLADE HEALTH AND REHABILITATION CENTER INC

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<td>outer foot...”</td>
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<td>f. 3/23/13 - &quot;...His wound is dressed daily to the left outer foot...&quot;</td>
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<td>g. 3/24/13 - &quot;...Wound care to the right foot daily...&quot;</td>
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<td>h. 3/29/13 - &quot;...He has a ulcer to the right outer foot...&quot;</td>
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Review of the facility's "NURSE'S ADMISSION / READMISSION ASSESSMENT" dated 12/31/13 documented, "...I heel red... soft..." Assessments of the wound were not documented consistently with the correct location of the wound.

Review of the weekly skin assessments dated 1/25/13, 1/31/13, 2/12/13, 2/15/13, 2/22/13, 3/1/13, 3/9/13, 3/13/13, 3/22/13 and 3/29/13 documented measurements of the wound with a decrease in size of the wound. There were no skin assessments documented for the weeks of 1/7/13, 1/14/13, 2/7/13 or 3/11/13. Skin assessments were not performed weekly.

During an interview at the nurses' station on 4/4/13 at 9:45 AM, Nurse #6 confirmed she had written the clinical notes [referring to right foot] and stated, "It should have been left outer foot [not right foot]... It was a blister that had ruptured..."

4. Medical record review for Resident #78 documented an admission date of 1/25/13 with diagnoses of Pneumonia, Esophageal Reflux Disease, Hypertension, Anemia, Diabetes Mellitus, Hypothyroidism, Thrombocytopenia, Hypertrophied, History of Fall, Malfunction of Vascular Device, Diarrhea, Abnormal Gait, Protein-Calorie Malnutrition, Reactive Depressive
F 272 Continued From page 9

Psychosis, Constipation, Osteoporosis, Coronary Artery Disease, Dialysis 3 times per week, History of Pulmonary Embolus and Sacral Decubitus. The initial nursing assessment dated 1/25/13 documented no pressure wounds. A physician’s order dated 2/11/13 documented, “...clean area to sacrum with NS pat dry, apply skin prep to periwound let dry and apply replicare, change Q3 [every 3] days and pm or can use hydrocolloid dressing...”

During an interview in the beauty shop on 4/3/13 at 4:30 PM, the ADON stated, “I remember this, the nurse just missed the wound on the admission assessment, it was in the crack area, the resident complained of her bottom hurting and that is when the wound was found as a stage 2, family was aware she had the area prior to admission here, the nurse just missed it on admission.” The surveyor asked the ADON to review the care plan and ask if care plan addressed the pressure sore. The ADON stated, “No, there is no care plan for the pressure sore.”

During an interview in the beauty shop on 4/3/13 at 5:40 PM, the DON stated, “Yes, I was the one who found her wound, her son told me she had the wound before she came here, when I talked to the admitting nurse she said she just did not see the area, it was right in the crack area.” The surveyor asked the DON to review the care plan and the DON stated, “Yes, this is not a care plan for her pressure sore, should have one that addresses the wound.”

The facility failed to accurately and completely assess the pressure wound for Resident #78.

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<th>F 278</th>
<th>483.20(g) - (j) ASSESSMENT</th>
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Corrective Action

F278

483.20 (g) - (j) ASSESSMENT ACCURACY/COORDINATION/ CERTIFIED

SS=D

REQUIREMENT: The assessment must accurately reflect the resident’s status.
Continued From page 10

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 assess 1 of 3 (Resident #57) incontinent residents reviewed of the 32 residents included in the stage 2 review.
F 278 Continued From page 11

The findings included:

Medical record review for Resident #57 documented an admission date of 7/10/09 with diagnoses of Congestive Heart Failure, Atrial Fibrillation, Hypertension, Abdominal Aortic Aneurysm, Depressive Psychosis, Anxiety, Alzheimer's Disease and Encephalopathy.

Review of the quarterly Minimum Data Set (MDS) with an assessment review date (ARD) of 1/14/13 documented Resident #57 was always continent. Review of the annual MDS with an ARD of 4/11/13 documented Resident #57 is always continent.

During an interview at the nurses station on 4/3/13 at 9:45 AM, Nurse #3 was asked if Resident #57 was incontinent. Nurse #3 stated, "She had a problem processing would wet her diaper and then say she had to go to the bathroom..."

During an interview in the MDS office on 4/3/13 at 8:45 AM, the MDS nurse confirmed that she had the wrong information [resident being continent] and would correct it.

F 280 SS=D 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

F 278

1) On resident #57 the MDS Coordinator modified the MDS to reflect incontinence and transmitted to the state with corrections on 4/4/13.

2) 100% chart review of the most recent MDS for complete and accurate assessments reflective of resident status at the time of the ARD of that assessment. This was completed by the Assistant Director of Nursing and MDS Coordinator between 4/5/13 to 4/8/13.

3) The MDS Coordinator was in-serviced on accurate assessment of MDS and revision of care plan based on the MDS 3.0 RAI Manual guidelines was completed on 4/4/13 by Regional Clinical Billing and Research Consultant.

4) The Q.A. Committee, consisting of Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Staffing Coordinator, Medical Records, Registered Dietician, Social Worker, Maintenance Supervisor, Activities Coordinator, will monitor for compliance through review of random auditing of patients MDS monthly for compliance. If compliance is not met the MDS coordinator will be re-in-serviced and audits will continue until substantial compliance is met.

Completed by 4/8/13
Continued from page 12:

interdisciplinary team, that includes the attending 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.

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 revise the comprehensive care plan to reflect interventions for falls for 1 of 16 (Resident #105) sampled residents reviewed of the 32 residents included in the stage 2 review.

The findings included:

Review of the facility’s care plan policy documented, "...Safety issues identified must all be addressed..."

Medical record review for Resident #105 documented an admission date of 2/7/13 with diagnoses of Mental Status Change, Urinary Tract Infection, Acute Encephalopathy, Gastro Esophageal Reflux Disease, Hypothyroidism, Dementia with Agitation and Macular Degeneration. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/13/13 revealed section J1800 was coded as yes indicating Resident #105 had...
F 280  Continued From page 13
experienced a fall since admission / last
assessment and section J1900 A was coded as
A-indicating a fall with no injury. Review of the
MDS with an ARD of 3/9/13 revealed section
J1800 was coded as yes indicating a fall since
last assessment and section J1900 B was coded
as 1- indicating a fall with injury.

Review of the facility's fall risk assessments for
Resident #105 documented the following:
a. 2/13/13 - the fall risk score as - 16.
b. 3/2/13 - the fall risk score as - 17.
The risk scale documented a total score of 11 to
(-) 19 indicated the resident is at a moderate risk
for falls.

Review of the nurse event notes documented the
following:
a. 2/13/13 documented, "...unobserved fall...
immediate steps implemented to
prevent recurrence... Body alarm remains
in progress with continuous monitoring..."
b. 3/2/13 - "...observed fall... abrasion to
buttock... immediate steps implemented
To prevent recurrence: make sure that
resident alarm is on and toileting q [every] 2h
[hours] and pm [as needed]..."
c. 3/14/13 - "...Unobserved fall... Immediate
Steps implemented to prevent
recurrence: Resident was placed back in
bed and informed to call for help if need to go to
the restroom and any other assistance bed alarm
in place..."

Review of the care plan dated 2/19/13 was not
revised to reflect interventions for the fall on
3/2/13.

2) 100% chart audit of patients who have had falls are reflective of risk
for falls with appropriate and
current interventions for falls are
in place with revisions made if
indicated was completed by MDS
and Assistant Director of Nursing
Monitoring of compliance with
appropriate interventions being
put in place to prevent falls with
care plan reflective of current
interventions will be done daily in
the morning meeting by the
Director of Nursing or Assistant
Director of Nursing

3) An In service on the Fall
Policy/Process to the Director of
Nursing, Assistant Director of
Nursing, and the MDS Coordinator
was conducted by Regional Billing
and Research Consultant on
An in-service for all nurses on the
Occurrence/Fall Policy was
conducted by Director of Nursing
on 4/5/13 and 4/15/13.

4) The Q.A. Committee, consisting of
Medical Director, Administrator,
Director of Nursing, Assistant
Director of Nursing, MDS
Coordinator, Staffing Coordinator,
Medical Records, Registered
Dietician, Social Worker,
Maintenance Supervisor,
Activities Coordinator, will monitor
**F 280**  
Continued From page 14  
Observations in Resident #105's room on 4/1/13 at 2:26 PM, revealed Resident 105 seated in a wheelchair (wc) in the doorway of the room with a chair alarm in place.

Observations in Resident #105's room on 4/3/13 at 7:40 AM and 10:00 AM, revealed Resident #105 lying in a low bed and both 1/2 side rails elevated with the call light within reach.

Observations on the 200 hall on 4/3/13 at 4:20 PM, revealed Resident #105 seated in a wc with a chair alarm in place.

During an interview in the MDS office on 4/3/13 at 3:45 PM, the MDS Nurse stated, "No I don't see interventions on the care plan for that fall [on 3/2/13] it should have been on there..."

**F 314**  
483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  
Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

Completed by 4/15/13

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 accurately assess and provide treatments to prevent the development of...
**Corrective Action**

1. Resident #37 was a discharged resident who discharged in November 2012. Resident #78 returned from the hospital on 4/10/13 and a complete assessment was done with no skin impairments noted. A thorough assessment of skin with documentation was completed on resident #68 on 4/4/13 by Staffing Coordinator, with care plan updated to reflect current status by MDS Coordinator on 4/4/13.

2. In an effort to identify other residents that may have been affected the staffing coordinator along with another nurse completed full body assessments on 100% or current residents on 4/4/13. Additional interventions were implemented on patients who presented any signs of skin compromise. Wound Care Specialist reviewed all current wounds for appropriate assessment, measurement, staging and treatment on 4/10/13. Nurses will perform weekly skin audits on all residents and document them.
### F 314
Continued From page 16

Film Dressing, change q [every] 3 days and PRN... Stage III-[lo] IV Wet Calcium Alginate Dressing or Collagen Wound Dressing, cover with foam or hydrocellular dressing, change q day and PRN...

2. Closed Medical record review for Resident #37 documented an admission date of 10/5/12 with diagnoses history of fall with Fracture Right Hip with Open Reduction Internal Fixation, Atrial Fibrillation, Hypertension, Anemia, Coronary Artery Disease, Parkinson's Disease, History of Myocardial Infarction, Hypothyroidism and Osteoarthritis. The initial admission nursing assessment dated 10/5/12 documented the resident's skin condition as pink, dry, intact and "redness to buttocks." The Braden Scale assessment dated 10/5/12 documented the resident at high risk for skin impairment. The initial care plan dated 10/5/12 documented the problem: "skin integrity" with intervention of "preventive care." A physician's order dated 10/7/12 documented, "clean area mid coccyx with NS [normal saline] or wound cleanser, apply Saniyp to slough and apply foam and cover qd until healed, Multivitamin with minerals qd [every day], Juven 1 pkg [package] in h2o [water] bid [twice a day] until wound resolved... coccyx ulcer st. [stage] III with slough." The Weekly Wound Progress Form dated 10/7/12 documented the wound as a stage 3 measuring 1.5 by (x) 0.6 x 0.1 centimeters with slough and documentation that the physician was not notified until 10/8/12. There was no documentation that the physician was notified of the redness to the buttocks as documented on admission. There was no documentation of any treatments documented per facility policy until 10/7/12 when the pressure on electronic administration record. Nurse management will perform weekly skin audits on all residents for three months. If compliance is maintained during these three months then nurse management will perform monthly skin audits.

3) CNAs were instructed & in-serviced by the Director of Nursing from 4/3/13 - 4/15/13 on the vital importance of their role in helping to identify & prevent skin ulcers. Charge nurses were instructed similarly regarding their responsibility to be vigilant & proactive in resident assessment duties each day to assure preventive and appropriate care is being delivered on 4/3/13-4/15/13 by the Director of Nursing and on 4/8/13 and 4/10/14 by the wound care specialist which incorporated skin assessments, treatments, documentation, and preventative measure responsibilities. After a thorough assessment of facility operations by the corporate QA staff it was determined that greater involvement by the nurse management team was needed to strengthen and attain more consistency in the skin care program. The facility has implemented weekly skin audits to record and monitor skin care.
**F 314** Continued From page 17

Sore had deteriorated to a stage 3 with slough.

During an interview on the 100 hall on 4/3/13 at 8:20 AM, Nurse #3 was asked about assessing pressure ulcers. Nurse #3 stated, "We assess, measure, start a wound sheet, get treatment orders and start treatments."

During an interview on the 200 hall on 4/3/13 at 9:00 AM, Nurse #4 was asked about assessing pressure ulcers. Nurse #4 stated, "I would assess the patient, measure the wounds, document it on the wound sheet, get orders and treat the wound. We measure wounds every Friday and document on the wound sheet."

During an interview in the beauty shop on 4/3/13 at 4:20 PM, the Assistant Director of Nursing (ADON), was asked about the 2/7/13 wound care order. The ADON stated, "That is our wound protocol for a stage 3. I wrote that from our wound protocol."

During an interview in the beauty shop on 4/3/13 at 4:30 PM, the ADON stated, "I consider redness as a stage one."

During an interview in the beauty shop on 4/3/13 at 5:15 PM, the ADON stated, "I would have expected a skin protectant to be used on the area [redness] according to our protocol."

During an interview in the beauty shop on 4/3/13 at 5:45 PM, the Director of Nursing (DON) was asked what should be done when redness is recognized on a resident. The DON stated, "Yes I would have expected the nurse to notify the MD [Medical Doctor] of the redness. I do consider that progress, delivery of treatments and effectiveness which involves nursing staff and management. Intensive in-services have been on going and will continue until satisfactory performance is achieved relative to assuring that identification of skin breakdown and corresponding intervention occurs to prevent avoidable skin ulcers and decubitus. Newly hired staff members will receive detailed orientation that will be specifically inclusive of the areas cited to assure newly enacted programs and quality care protocols will be followed.

4) The Q.A. Committee, consisting of Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Staffing Coordinator, Medical Records, Registered Dietician, Social Worker, Maintenance Supervisor, Activities Coordinator will monitor compliance through resident rounds and chart audits weekly for three months. If compliance is not met the facility nursing staff will be re-in-serviced and audits will continue until substantial compliance is met. Different members of the committee will participate depending on the nature of the audit. Random audits by the Clinical Billing and Research Consultant will be conducted for...
F 314: Continued From page 18

[redness] a stage one and there should have been a treatment put in place."

During an interview in the beauty shop on 4/4/13 at 2:20 PM, the Nurse Practitioner confirmed he was not notified of the wound until 10/8/12.

The failure of the facility to timely notify the physician, obtain and provide treatments to the pressure sore resulted in actual harm to Resident #37 when the resident's pressure sore deteriorated to a stage 3 wound.

3. Medical Record review for Resident #68 documented an admission date of 12/31/12 with diagnoses of Rehabilitation Process, Deep Vein Thrombosis, Muscle Weakness, Symbolic Dysfunction, Senile Dementia, Chronic Airway Obstruction, Bladder Cancer, Spinal Stenosis, Flu, Esophageal Reflux, Bladder Cancer, Constipation, Vitamin D Deficiency and Pneumonia. Review of a physician's order dated 1/30/13 documented, "...Cleanse left outer (L) [left] foot near toe c [with] NS or wet cleanser. Apply Hydrogel gauze/oointment. Change daily..."

Review of a Clinical Notes documented the following:

a. 1/29/13 - "...Noted that he has a open area on the left out [outer] heel... New order to treat the heel wound and heel were placed [placed] on pillow..."

b. 2/18/13 - "...Slough noted during treatment to L outer toe..."

c. 2/20/13 - "...Pt [patient] with Stage II PrU [pressure ulcer] noted to L outer foot..."

d. 3/17/13 - "...His left side of foot has ulcer that receives daily dressing. Still has some slough..."

the next three months to assure the accuracy of the reports and to improve patient safety and skin integrity.

Completed by 4/20/13
F 314 Continued From page 19 present:

  e. 3/20/13 - "...redressed the wound to the right outer foot..."
  f. 3/23/13 - "...His wound is dressed daily to the left outer foot..."
  g. 3/24/13 - "...Wound care to the right foot daily...
  h. 3/29/13 - "...He has a ulcer to the right outer foot..."

Review of the facility's "NURSE'S ADMISSION/READMISSION ASSESSMENT" dated 12/31/13 documented, "...heel red... soft..." Assessments of the wound were not documented consistently with the correct location of the wound.

Review of the weekly skin assessments dated 1/25/13, 1/31/13, 2/12/13, 2/15/13, 2/22/13, 3/1/13, 3/9/13, 3/18/13, 3/22/13 and 3/29/13 documented measurements of the wound with a decrease in size of the wound. There were no skin assessments documented for the weeks of 1/7/13, 1/14/13, 2/7/13 or 3/11/13. Skin assessments were not performed weekly.

During an interview at the nurses' station on 4/4/13 at 9:45 AM, Nurse #6 confirmed she had written the clinical notes [referring to right foot] and stated, "It should have been left outer foot [not right]... it was a blister that had ruptured..."

4. Medical record review for Resident #78 documented an admission date of 1/25/13 with diagnoses of Pneumonia, Esophageal Reflux Disease, Hypertension, Anemia, Diabetes Mellitus, Hypothyroidism, Thrombocytopenia, Hypertrophied, History of Fall, Abnormal Gait, Diarrhea, Malfunction of Vascular Device,
F 314 Continued From page 20

Protein-Calorie Malnutrition, Reactive Depressive Psychosis, Constipation, Osteoporosis, Coronary Artery Disease, Dialysis 3 times per week, History of Pulmonary Embolus and Sacral Decubitus.

The Initial nursing assessment dated 1/25/13 documented no pressure wounds. A physician's order dated 2/7/13 documented, "...clean area to sacrum with NS pat dry, apply skin prep to periwound let dry and apply replicare, change Q3 [every 3] days and prn or can use hydrocolloid dressing...."

During an interview in the beauty shop on 4/3/13 at 4:30 PM, the ADON stated, "I remember this, the nurse just missed the wound on the admission assessment, it was in the crack area, the resident complained of her bottom hurting and that is when the wound was found as a stage 2, family was aware she had the area prior to admission here, the nurse just missed it on admission." The surveyor asked the ADON to review the care plan and asked if care plan addressed the pressure sore. The ADON stated, "No, there is no care plan for the pressure sore."

During an interview in the beauty shop on 4/3/13 at 5:40 PM, the DON stated, "Yes, I was the one who found her wound, her son told me she had the wound before she came here, when I talked to the admitting nurse she said she just did not see the area, it was right in the crack area." The surveyor asked the DON to review the care plan and the DON stated, "Yes, this is not a care plan for her pressure sore, should have one that addresses the wound."

The facility failed to accurately and completely assess the pressure wound and failed to develop...
F 314  Continued From page 21
        a care plan that addressed the pressure wound for Resident #78.

F 323  483.25(h) FREE OF ACCIDENT
        HAZARDS/SUPERVISION/DEVICES

        The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure a new intervention was put in place after each fall for 1 of 3 (Resident #105) sampled residents with falls of the 32 residents included in the stage 2 review.

The findings included

Review of the facility's care plan policy documented, "...Safety issues identified must all be addressed..."

Medical record review for Resident #105 documented an admission date of 2/7/13 with diagnoses of Mental Status Change, Acute Encephalopathy, Urinary Tract Infection, Gastro Esophageal Reflux Disease, Hypothyroidism, Dementia with Agitation and Macular Degeneration. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/13/13 revealed section J1800 was

F 323  483.25 (H) FREE OF ACCIDENT
        HAZARDS/SUPERVISION/DEVICES
        SS= D

REQUIREMENT:
The facility must ensure that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

1) Resident #105 care plan was revised to reflect current interventions related to falls on 4/4/13 by the MDS Coordinator.

2) 100% of chart reviews of all patient care plans who have had a fall or are reflective of risk for falls with appropriate and current interventions for falls are in place with revisions made if indicated. Completion date 4/5/13.
**F 323**

Continued From page 22

coded as yes indicating Resident #105 had experienced a fall since admission / last assessment and section J1900 A was coded as A-indicating a fall with no injury. Review of the MDS with an ARD of 3/9/13 revealed section C was coded for problems with short and long term memory, section J1800 was coded as yes indicating a fall since last assessment and section J1900 B was coded as 1-indicating a fall with injury.

Review of the facility's fall risk assessments for Resident #105 documented the following:

a. 2/13/13 - the fall risk score as = 16.
b. 3/2/13 - the fall risk score as = 17.

The risk scale documented a total score of 11 to (-) 19 indicated the resident is at a moderate risk for falls.

Review of the nurse event notes documented the following:

a. 2/13/13 documented, "...unobserved fall...

**IMMEDIATE STEPS IMPLEMENTED TO PREVENT RECURRANCE...** Body alarm remains in progress with continuous monitoring."  
b. 3/2/13 - "...Observed fall... abrasion to butlock... **IMMEDIATE STEPS IMPLEMENTED TO PREVENT RECURRANCE:** make sure that resident alarm is on and toileting q [every] 2h [hours] and prn [as needed]."

c. 3/14/13 - "...Unobserved fall... **IMMEDIATE STEPS IMPLEMENTED TO PREVENT RECURRANCE:** Resident was placed back in bed and informed to call for help if need to go to the restroom and any other assistance bed alarm in place..."

Review of the care plan dated 2/19/13 was not
<table>
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<tr>
<th>ID</th>
<th>TABLE</th>
<th>TAG</th>
<th>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</th>
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<td>[X1] PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER</td>
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<td>[X2] MULTIPLE CONSTRUCTION</td>
<td>A BUILDING</td>
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<td>B WING</td>
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<td>[X3] DATE SURVEY COMPLETED</td>
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<tr>
<td>NAME OF PROVIDER OR SUPPLIER</td>
<td>BRIGHT GLADE HEALTH AND REHABILITATION CENTER INC</td>
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</tr>
<tr>
<td>STREET ADDRESS, CITY, STATE, ZIP CODE</td>
<td>5070 SANDERLIN AVENUE MEMPHIS, TN 38117</td>
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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>[X5] COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 323</td>
<td>F 323</td>
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<td>revised to reflect interventions for the fall on 3/2/13.</td>
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<td>Observations in Resident #105's room on 4/1/13</td>
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<td>at 2:26 PM, revealed Resident 105 seated in a wheelchair (wc) in the doorway of the room with chair alarm in place.</td>
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<td>Observations on the 200 hall on 4/3/13 at 4:20 PM, revealed Resident #105 seated in a wc with a chair alarm in place.</td>
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<td>During an interview in the MDS office on 4/3/13 at 3:45 PM, the MDS Nurse stated, &quot;No I don't see interventions on the care plan for that fall [referring to fall on 3/2/13] it should have been on there...&quot;</td>
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<td>F 332</td>
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<td>SS=D</td>
<td>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</td>
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<td>The facility must ensure that it is free of medication error rates of five percent or greater.</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure 2 of 6 (Nurses #3 and 4) nurses administered medications with a medication error rate of less than five percent (%). There were 2 medication errors out of 29</td>
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483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE

The facility must ensure that it is free of medication error rates of five percent or greater.

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 2 of 6 (Nurses #3 and 4) nurses administered medications with a medication error rate of less than five percent (%). There were 2 medication errors out of 29
F 332  Continued From page 24
opportunities for error, which resulted in a medication error rate of 6.8%.

The findings included:


Observations during medication administration in Resident #89's room on 4/3/13 at 9:38 AM, Nurse #3 did not clean the area of skin before applying the Exelon patch to Resident #89's right upper back and did not clean the area of skin where the previous patch was located and removed. Failure to clean the skin resulted in medication error #1.

During an interview at the nurse's station on 4/4/13 at 2:14 PM, the DON was asked how medication patches should be applied. The DON stated, "Take the old patch off, clean the area before the new patch is applied... let it dry... apply the new patch..."

2. Review of the facility's "Eye Ointment Administration Procedure for Adults" documented, "...Use gauze to pull down lower eyelid to form a [pouch], instructing patient to look up... apply a thin line of ointment into the pouch. (Do not touch eye with medication container)..."

Medical record review for Resident #44 documented an admission date of 1/31/08 with...
### Statement of Deficiencies and Plan of Correction

**X1 Provider/Supplier/CLA Identification Number:** 445426

**X2 Multiple Construction**
- A: Building
- B: Wing
- C: Building
- D: Wing

**X3 Date Survey Completed:** 04/04/2013

#### Bright Glade Health and Rehabilitation Center Inc

**Address:** 5070 Sanderlin Avenue, Memphis, TN 38117

#### Summary Statement of Deficiencies

<table>
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<tr>
<th>ID Prefix Tag</th>
<th>Description</th>
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| F 332         | Continued From page 25 diagnoses of Late effects of Hemiplegia, Anxiety, Gastrointestinal Hemorrhage, Aphasia, Hypertension, Psychosis, Conjunctivitis, Entropion, Depressive Disorder, Esophagitis, Alzheimer's Disease and Senile Delusion. Review of a physician's order dated 2/6/13 documented, "...Refresh Lactulose ointment to ½" [symbol for inch] (R) [right] eye BID [twice a day] indefinitely..."

Observations of medication administration in Resident #44's room on 4/3/13 at 8:45 AM, Nurse #4 rubbed the ointment over both eyelids instead of applying to the right inner eyelid. The failure to apply the ointment in the lower lid pouch of the right eye and applying the ointment on the left eye resulted in medication error #2.

During an interview on the 200 hall, at the medication cart, on 4/4/13 at 12:45 PM, Nurse #4 was asked how the order was written for the Refresh Lactulose for Resident #4. Nurse #4 looked at the Medication Administration Record and read the order as written. Nurse #4 stated, "It should have only been in the right eye... He really needs it in both eyes... I need to let the doctor know so he could write an order..." Nurse #4 was then asked how the Refresh Lactulose should be applied according to the directions. Nurse #4 stated, "It goes in the eye... I should have put it in the eye..."

During an interview in the nursing office on 4/4/13 at 2:43 PM, the Director of Nursing (DON) was asked how eye ointment should be applied. The DON stated, "Pull the bottom eyelid down... apply the amount of ointment..."

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</thead>
<tbody>
<tr>
<td>F 371</td>
<td>483.35(i) FOOD PROCURE, 483.35(f) MEDICATION ADMINISTRATION</td>
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</tbody>
</table>
F 371 Continued From page 26

SS-D

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 2 of 8 staff members (Certified Nursing Assistants (CNA) #3 and 4) failed to practice sanitary hand hygiene during dining observations. The facility failed to ensure the nourishment refrigerator was free from expired food items and frozen items were kept frozen. The facility failed to ensure items in the nourishment room were labeled and dated when opened.

The findings included:

1. Review of the facility's "Dining Room Meals" policy documented, "...CNAs must wash their hands or use hand sanitizer between patients if contact with anyone or anything other than meal tray occurred..."

Observations in the dining room on 4/1/13 at 12:05 PM, revealed CNA #3 applied a clothing protector to a resident, patted the protector down in the lap of the resident, went to the next
<table>
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<th>TAG</th>
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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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<tbody>
<tr>
<td>F 371</td>
<td>Continued From page 27</td>
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<td>Resident and applied a clothing protector to that resident, patted the protector down in the resident's lap, applied a clothing protector to another resident, patted the protector down in the resident's lap, handed a clean clothing protector to another resident, went to the next resident applied a protector, moved a wheelchair up to the table, picked up a stack of clean protectors placed all of the protectors on another table (assisted feeding table) and then used hand gel. CNA #3 did not use hand gel between touching each resident.</td>
<td>3) All department staff to monitor dining room daily during meals for proper and hygiene. The Registered Dietician or dietary designee will also monitor nourishment refrigerator weekly for properly labeled items and any expired items. 4) The Q.A. Committee, consisting of Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Staffing Coordinator, Medical Records, Registered Dietician, Social Worker, Maintenance Supervisor, Activities Coordinator, will monitor for compliance through review of facility rounds and documented audits for three months. If compliance is not met, facility staff will be re-in serviced and audits will continue until substantial compliance is met. completed by 4/15/13</td>
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<td>F 371</td>
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<td>Observations in the dining room on 4/1/13 at 12:15 PM, CNA #4 patted a resident on her left shoulder, went to the drink station, obtained a container of juice and returned to the resident, patted the resident and then used gel. CNA #4 did not use hand gel before obtaining a drink from the drink station.</td>
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</tbody>
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Continued From page 28

4/3/13 at 5:00 PM, Nurse #2 verified there were expired items in the refrigerator.

During an interview in the beauty shop on 4/3/13 at 5:10 PM, the Assistant Director of Nursing (ADON) was asked who was responsible for cleaning the nourishment refrigerator and for removing expired / outdated items. The ADON stated, "The night shift is responsible for cleaning it. They are supposed to clean and throw out old or outdated items..."

3. Observations in the nourishment room on 4/3/13 at 4:30 PM, revealed an opened bottle of a High Protein shake was not dated.

483.60 (b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS

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

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

REQUIREMENT:
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.
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.

This REQUIREMENT is not met as evidenced by:

Based on policy review, observation and interview, it was determined the facility failed to ensure medications were stored in clean, locked compartments at all times and medications were not stored past their expiration date in 2 of 3 (100 and 200 hall medication carts) medication carts.

The findings included:

1. Review of the facility's "MEDICATION STORAGE" policy documented, "...Routine checks must be accomplished to ensure that expired medications are discarded... Medications must be properly stored in medication rooms or medication carts and must be securely locked when not in use..."

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 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.

Corrective Action

1) In-service with nurse #1 and nurse #5 who had left medication carts unlocked was conducted on 4/5/13 by the Director of Nursing. In service of all nurses on secured medications and expired medications were conducted by the Director of Nursing and
Continued From page 30

Review of the facility's "MEDICATION CART" policy documented, "...Clean and organized..."

2. Observations on the 100 hall on 4/2/13 at 4:53 PM, Nurse #5 left the medication cart unlocked while administering medications in Room 102. At 4:55 PM the Director of Nursing (DON) walked by and locked the cart.

During an interview on the 100 hall on 4/2/13 at 4:56 PM, Nurse #5 was asked should the medication cart be locked when you are not at the cart. Nurse #5 stated, "Yes, it should be locked."

During an interview at the nurses station on 4/2/13 at 5:01 PM, the DON was asked what were expectations of the charge nurses in regard to the medication carts. The DON stated, "...Make sure they lock the cart when they leave it..."

3. Observations on the 200 hall on 4/1/13 at 11:56 AM, revealed the 200 hall medication cart was unlocked, unattended and out of the nurse's view.

During an interview on the 200 hall on 4/1/13 at 11:56 AM, the Assistant Director of Nursing (ADON) stated, "Was that left [200 hall medication cart] unlocked..." The ADON verified the 200 hall medication cart was left unlocked, unattended and out of the nurse's view.

During an interview on the 200 hall on 4/1/13 at 12:05 PM, Licensed Practical Nurse (LPN) #1 stated, "Ma'am my lock is broken I put it on there [referring to lock] yesterday... I guess I didn't push it [lock] in hard enough..."
F 431
Continued From page 31
Observations on the 200 hall on 4/3/13 at 8:12 AM, revealed the top drawer of the right side of the cart revealed the drawer was dirty had a dirty broken pill cutter in it. The 3rd side drawer with liquids had sticky residue with hair and dirty particles stuck in it. The 3rd big drawer had a bag of vials of Promethazine Injection 25 milligram (mg) per (i) milliliter (ml) with a date of 3/26/11. There were 3 vials with an expiration date of 12/2012; 2 vials with an expiration date of 11/2012; 1 vial with an expiration date of 8/2012 and 1 vial with an expiration date of 9/2012.

During an interview on the 200 hall on 4/3/13 at 8:12 AM, Nurse #4 stated, "...that is old, the expiration date is definitely out on these [vials of Promethazine]."

During an interview in the DON office on 4/3/13 at 8:48 AM, the DON was asked how often the medication carts are checked. The DON stated, "They are checked monthly... or weekly if needed..." The DON was then asked who is responsible for keeping the medication carts clean. The DON stated, "...The nurses... They are supposed to clean up after themselves... and keep the carts clean..."

F 463
483.70 (f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH

The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.

This REQUIREMENT is not met as evidenced by:
Continued From page 32

Based on observation and interview, it was determined the facility failed to provide a functioning call light in 1 of 2 (central bath) baths.

The findings included:

Observations in the central bath on 4/3/13 at 11:00 AM and on 4/3/13 at 5:30 PM, revealed the call light in shower stall one and the room adjacent to the shower did not light up outside the central bath room. There was not a call light system in the second shower stall.

During an interview in the central bath on 4/3/13 at 5:30 PM, the Maintenance Supervisor verified that the call light system was not functioning properly.

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

This REQUIREMENT is not met as evidenced by:

Based on observation and interview, it was determined, the facility failed to ensure handrails were firmly secured on 2 of 3 (100 and 300 halls) halls.

The findings included:

1. Observations of the handrails on the 100 hall on 4/3/12 beginning at 10:39 AM, revealed the following:
   a. The handrail between rooms 109 and 107 was loose.

   1) The call light in the central bath was fixed on 4/5/13. The Maintenance Supervisor was in-service on monitoring equipment/call lights for proper function by the Administrator on 4/4/13. All staff was in-service on 4/4/13 on reporting dysfunctional equipment by the Maintenance Supervisor.

   2) A 100% audit was conducted on 4/5/13 by the Administrator and Maintenance supervisor that all call lights were functioning appropriately in all resident rooms, bathrooms, and central bath locations.

   3) Random daily audits will be done by facility walking rounds by the maintenance and department head staff.

   4) The Q.A. Committee, consisting of Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Staffing Coordinator, Medical Records, Registered Dietician, Social Worker, Maintenance Supervisor, Activities Coordinator, will monitor for compliance through review of facility rounds and documented audits for three months. If compliance is not met, facility staff will be re-trained and audits will continue until substantial compliance is met.

Completed by 4/5/13
Continued From page 33

b. The handrails between rooms 109 and 111 was loose.

2. Observations of the handrails on the 300 hall on 4/3/13 beginning at 10:34 AM, revealed the following:
   a. The handrail between rooms 312 and 314 was loose.
   b. The handrail between rooms 317 and 315 was loose.
   c. The handrail between 303 and 301 was loose.

During an interview on the 300 hall on 4/3/13 at 11:40 AM, the maintenance supervisor verified the handrails were loose and stated, "It's not unusual to have to tighten them..."