

AUG 22 2013

PRINTED: 08/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445321	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/07/2013
NAME OF PROVIDER OR SUPPLIER  ARDMORE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 25385 MAIN STREET ARDMORE, TN 38449	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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 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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and interview, it was determined the facility failed to ensure care plans were revised to include new fall interventions for 2 of 16 (Residents #21 and 75) sampled residents reviewed of the 29 residents included in the stage 2 review.</p> <p>The findings included:</p> <p>1. Review of the facility's "7.0 Falls Management" policy documented, "...Those determined to be at risk will receive appropriate Interventions to reduce risk and minimize injury... revise care plan</p>	F 280	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Ardmore Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>F 280</p> <p>The care plans for residents #21 and #75 were immediately updated with appropriate interventions on 8/7/2013.</p> <p>The Unit Manager audited charts on 8/7/2013 for residents that had fallen in the past 14 days verifying a revised care plan. No deficiencies were noted during this audit.</p> <p>Licensed nurses were re-educated on the falls management policy, including updating a resident's care plan following an accident/incident on 8/16/2013 by Nursing Management.</p> <p>The facility will ensure ongoing compliance with the Unit Manager or designee auditing resident's charts following an incident/accident for revision of the resident's care plan x 3 months.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Christine Taylor*

*Administrator*

*8/21/13*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 280	<p>Continued From page 1 regularly..."</p> <p>2. Medical record review for Resident #21 documented an admission date of 4/1/11 with diagnoses of Alzheimer's Disease, Hypertension, Hypertrophy of Prostate, Insomnia, Chronic Obstructive Pulmonary Disease, Stiffness of Joint, Osteoarthritis and Generalized Pain. Review of the quarterly Minimum Data Set (MDS) dated 7/10/13 for Resident #21 revealed a Brief Interview Mental Status (BIMS) score of 13 indicating the resident's cognition was intact and had one fall since admission. Review of a Physician's order dated 7/9/13 documented, "...x-ray to bilateral ribs, thoracic spine, and left hip... fall..." Review of the "Change of Condition Documentation" for Resident #21 dated 7/9/13 documented a fall with an intervention to encourage the resident to call for assistance when reaching for things. Review of the care plan dated 7/13/13 documented Resident #21 had a fall on 7/9/13 and no new intervention was documented.</p> <p>During an interview at the nurses' station on 8/7/13 at 8:25 AM, the Director of Nursing (DON) was asked to review Resident #21's care plan for an intervention after the fall on 7/9/13. The DON stated, "...they [staff] failed to revise [the care plan]..."</p> <p>3. Medical record review for Resident #75 documented an admission date of 7/18/13 with diagnoses of Paralysis Agitans, Rhabdomyolysis, Dementia with Behavioral Disturbance, Shoulder Joint Pain, Atherosclerosis, Major Depressive Disorder, Chronic Pain, Anxiety Disorder and Hypertrophy of Prostate. Review of the "Change of Condition Documentation" form for Resident</p>	F 280	<p>The Interdisciplinary Team will also review care plans during the weekly Customer At Risk meeting to ensure revision has occurred following an incident/accident.</p> <p>Audit results will be reviewed by the Performance Improvement Committee monthly X 3 and further as needed. The Performance Improvement committee consists of the Administrator, Medical Director, Director of Nurses, Unit Manager, Health Information Manager, Business Office Manager, Social Services, Maintenance Director, Recreation Director, and Director of Food Services. Ongoing audits will be determined as needed by the PI committee.</p> <p>Date of Compliance</p>	9/5/13	

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F 280	Continued From page 2 #75 documented a fall on 8/3/13. Review of the care plan dated 7/18/13 documented no intervention for Resident #75's fall on 8/3/13. Review of the admission MDS dated 7/25/13 documented no falls since admission.  Observations in Resident #75's room on 8/5/13 at 2:38 PM, revealed Resident #75 sitting in a wheelchair, awake, alert and oriented with an intact bandage on her left forearm. Resident #75 stated, "I fell going to bathroom... feet got tangled up... first time I fell here..."  Observations in the therapy room on 8/6/13 at 7:53 AM, revealed Resident #75 sitting in a chair with a hot pack to the right shoulder. Resident #75 stated, "...I have chronic pain..."  During an interview at the nurses' station on 8/7/13 at 9:35 PM, the DON was asked to review the care plan for Resident #75 dated 7/18/13 for an intervention for the 8/3/13 fall. The DON stated, "...don't see one [intervention put in place after the 8/3/13 fall]..."	F 280			
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F 371  Any persons entering the kitchen with facial hair is provided an appropriate beard restraint provided by the facility. A beard restraint has been worn by the dietary manager (being the only current employee with facial hair) since the identification of the issue on 8/7/2013.		

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F 371	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure the Dietary Manager (DM) prepared, stored and served food under sanitary conditions as evidenced by not covering his facial hair on 2 of 3 (8/6/13 and 8/7/13) days of the survey.</p> <p>The findings included:</p> <p>Review of the facility's "STAFF ATTIRE" policy documented, "...The Nutritional Services Director that all staff members have their... facial hair properly restrained..."</p> <p>Observations in the kitchen on 8/6/13 at 8:00 AM and on 8/7/13 at 2:30 PM, the DM did not have a covering over his mustache, while providing a tour of the kitchen.</p> <p>During an interview in the Administrator's office on 8/7/13 at 3:30 PM, the Administrator was asked what was expected of kitchen staff with facial hair. The Administrator stated, "Should wear a beard and/or mustache covering."</p>	F 371	<p>In order to identify further any residents at potential risk, the facility administrator or designee will visually inspect 3 X per week at random intervals X 4 weeks to ensure that all persons in the kitchen are wearing appropriate beard restraints if required.</p> <p>The facility administrator completed re-education with the Dietary Manager on 8/13/13 regarding the purpose of wearing beard restraints, the potential risk of the Audit results will be reviewed by the failure to wear appropriate beard restraints, the provision of beard restraints by the facility, and the expectation that beard restraints are to be worn at all times.</p> <p>The center will ensure ongoing compliance with the Administrator or designee visually inspecting 4 X per month at random intervals X 3 months to ensure that all persons in the kitchen are wearing appropriate beard restraints if required.</p> <p>Performance Improvement Committee monthly X 3 and further as needed. The Performance Improvement committee consists of the Administrator, Medical Director, Director of Nurses, Unit Manager, Health Information Manager, Business Office Manager, Social Services, Maintenance Director, Recreation Director, and Director of Food Services. Ongoing audits will be determined as needed by the PI committee.</p> <p>Date of Compliance</p>	9/5/13	