

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

PRINTED: 01/07/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445235	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/06/2016
NAME OF PROVIDER OR SUPPLIER BOULEVARD TERRACE REHABILITATION AND NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1530 MIDDLE TENNESSEE BLVD MURFREESBORO, TN 37130		
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F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, care plan review and interview, the facility failed to developed a care plan for the psychotropic medication, Risperdal, for 1 (Resident #77) of 33 residents reviewed.</p> <p>The findings included:</p> <p>Medical record review revealed Resident #77 was originally admitted to the facility on 4/22/15, discharged to the hospital on 12/25/15, and readmitted to the facility on 12/28/15 with diagnoses including Dementia without Behavioral</p>	F 279	<p>This Plan of Correction affirms our allegation of compliance for the deficiencies cited, however, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction has been respectfully developed and submitted as required for compliance with federal and state regulations</p> <p>F 279 1. Resident # 77's care plan was updated on 1/6/15 by the RN MDS Coordinator. 2. All residents who are prescribed anti-psychotic and psychotropic medications have the potential to be affected by the deficient practice of failing to develop a care plan addressing medications. In-house residents, who are on anti-psychotic and psychotropic medications, care plans were audited on 1-12-16 by the Director of Nursing and RN MDS Coordinator to ensure that there was an active care plan addressing their psychotropic medications. Other residents found to be on a psychotropic medication without a care plan were corrected immediately, by the RN and LPN MDS coordinator on 1-12-16.</p>	02-06-16	

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

TITLE

(X6) DATE

Amelia Bagwood, RN

Administrator

1-14-16

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 279	Continued From page 1 Disturbances, Chronic Pain, Hypertension, Diabetes Mellitus Type 2, Convulsion, Atrial Fibrillation, Depression, and Obstructive Sleep Apnea. Medical record review of the physician orders and the Medication Administration Records revealed from the admission on 4/22/15 through the discharge on 12/25/15 Risperdal, anti-psychotic medication, 1 milligram by mouth at bedtime was ordered and administered. Resident #77 was readmitted to the facility on 12/28/15 with Risperdal 1 milligram by mouth at bedtime. Medical record review of the Admission Minimum Data Set (MDS) dated 5/7/15, Quarterly MDS dated 7/30/15 and 10/30/15 and the Admission MDS dated 1/4/16 revealed Resident #77 was administered anti-psychotic medication for 7 of the 7 day look back period. Medical record review of the care plan initiated on 5/7/15 through the discharge on 12/25/15 and the initial readmission care plan after 12/28/15 revealed the anti-psychotic medication was not addressed. Interview with the MDS Coordinator #1 on 1/6/16 at 10:45 AM in the conference room confirmed the care plans from 5/7/15 through 12/25/15 and the readmission care plan after 12/28/15 failed to address the anti-psychotic medication.	F 279	3. Education began on 1/6/15 by the Vice President of Clinical Reimbursement to the facility MDS Department related to ensuring resident's care plans reflect the use of anti-psychotic medications. Further education will be done with licensed nurses on all shifts by the Nurse Educator or designee related to updating residents care plans when a psychotropic medication is added or discontinued from their plan of care. Education will be completed by February 6, 2016 4. New orders and discontinued orders will be reviewed by the DON or designee during the weekday morning clinical meeting verifying that residents who received new orders or discontinuation of anti-psychotic medications are care planed. This audit will occur 5x a week and will be ongoing. Results will be reviewed by QAPI x3 months. Any aberrancies will be addressed, interventions developed and corrective action taken. 5. February 6, 2016	02-06-16	
F 323 SS=D	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	F 323	F 323 1. Resident #94 discharged home on 8/10/15.	02-06-16	

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F 323	<p>Continued From page 2</p> <p>adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, facility investigation review, and interview, the facility failed to conduct a thorough investigation of two falls sustained by a resident for 1 (Resident #94) of 33 residents reviewed.</p> <p>The findings included:</p> <p>Review of the facility policy entitled Falls Standard, revised November 2014, revealed "...Investigations of unusual events are conducted by, or at the direction of, the administrator or a designee of the Quality Assurance Performance Improvement Committee (QAPI). Documents created during the investigation are forwarded to the QAPI Committee for review, analysis, and retention...If the cause is unknown describe any known factors leading up to the event or resident conditions that may have contributed to the event. Also include the immediate corrective actions taken..."</p> <p>Medical record review revealed Resident #94 was admitted to the facility on 7/15/15, with diagnoses including Posttraumatic Stress Disorder secondary to husband's death, Hyperlipidemia, Depression with Psychotic Features, Congenital Birth Defect of Right Arm, Osteoporosis, and History of Small Bowel Obstruction.</p> <p>Medical record review of the Annual Minimum</p>	F 323	<p>2. All residents who sustain a fall have the potential to be affected by the alleged deficient practice of failing to conduct a thorough investigation. An action plan was created in October 2015 related to facility falls and ensuring post fall assessment and analysis was completed per the facility policy. An audit was done on 1-11-15 on all falls by the facility Director of Nursing back to 11/13/15, the date certain for the facility complaint survey that ended on 9/29/15. All falls were found to have been thoroughly investigated per the facility protocol.</p> <p>3. Education began on 1/11/16 by the Administrator or designee to licensed personnel on all shifts related to the facility policy post fall investigation, collecting witness statements, and conducting a root cause analysis. New hire staff will receive in-service education during orientation on facility policy related to falls by the Director of Nursing or Designee.</p> <p>4. The DON or designee will audit post fall documentation during the morning clinical meeting to verify adherence to policy, to include proper documentation, notification, interventions and following the investigational process. This audit will occur 5x a week and will be ongoing.</p>	02-06-16	

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F 323	<p>Continued From page 3</p> <p>Data Set dated 8/12/15, revealed Resident #94 required supervision with transfer; extensive assistance with dressing, toileting, and grooming; total assistance of one person for bathing; and supervision with eating.</p> <p>Medical record review of nursing notes dated 7/31/15, revealed "...SW (Social Worker) notified nurse that resident fell early morning on 7/31/15. Explained to daughter there will be a bed alarm put in place at night..."</p> <p>Review of the first page of the incident report revealed "...Resident (#94) observed sitting on the fall mat in front of B bed in another resident's room. Resident's vital signs were taken and she was assisted to her room and her bed..." There were no further pages of the incident report.</p> <p>Attempted review of the facility investigation revealed no investigation was available to determine the root cause analysis or immediate interventions put into place.</p> <p>Medical record review of nursing notes dated 08/09/15, revealed "...Resident was walking in hall when other residents notice that she had taken a sit in the floor. No injuries was noted..."</p> <p>Review of the first page of the incident report revealed "...When I got to C hall the resident (#94) was sitting on her bottom. Resident was unable to communicate with staff..." There were no further pages of the incident report.</p> <p>Attempted review of the facility investigation revealed no investigation was available to determine the root cause analysis or immediate interventions put into place.</p>	F 323	<p>4. (continued) Results will be reviewed by QAPI x3 months. Any aberrancies will be addressed, interventions developed and corrective action taken.</p> <p>5. February 6, 2016</p>	02-06-16	

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F 323	Continued From page 4	F 323			
F 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain an accurate and complete medical record for 1 (Resident #96) of 33 resident's reviewed.</p> <p>The findings included:</p>	F 514	<p>F 514</p> <p>1. Resident # 96 was discharged home on 9/8/15.</p> <p>2. All residents who are newly admitted to the facility have the potential to be affected by the alleged deficient practice of an incomplete and inaccurate medical record. An audit was done by the Facility Medical Records Coordinator, LPN on all new admissions since 11/13/15; the date certain of the complaint survey ending on 9-29-15; to verify that new admissions accurately identify the transferring facility, have an accurate admitting diagnosis and a complete assessment is completed on all new residents. Any resident found to have an incomplete assessment had the missing section of the assessment re-assessed by a licensed nurse. This was/will be completed by 1-18-16.</p>	02-06-16	

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F 514	<p>Continued From page 5</p> <p>Medical record review revealed Resident #96 was admitted to the facility on 8/4/15 and discharged to home on 9/8/15. Diagnoses included Anorexia, Dementia with Behavioral Disturbances, Hypertension and Psychosis.</p> <p>Medical record review of the 5 day Minimum Data Set dated 8/11/15 revealed the resident had not had a fall any time during the previous 6 months.</p> <p>Medical record review of a Doctor's order sheet dated 8/4/15 revealed "...Diagnosis: Dementia [with] behaviors, HTN (Hypertension), hypothyroidism, hyperlipidemia, psychosis, anorexia..."</p> <p>Medical record review of a Nursing Admit/Readmit Information form dated 8/4/15 revealed the resident had come from a medical hospital in Nashville, TN and the admitting diagnosis was "FALL". Continued review revealed the Mobility/Safety Fall Risk Assessment portion of the form was left blank.</p> <p>Medical record review of a Physician's Telephone Orders sheet dated 8/6/15 revealed, "...Late Entry Effective 8/5/15: PT (Physical Therapy) Clarification Order: Resident to receive skilled PT services...for... personal history of falls..."</p> <p>Medical record review of a Physician's Visit form to the resident dated 8/6/15 revealed, "...The Patient was admitted from (named a mental health facility in Franklin, TN)...Patient was hospitalized with behavioral disturbances...History obtained from...chart..."</p> <p>Interview with the Administrator on 1/5/15 at 3:30 PM in the conference room stated Resident #96</p>	F 514	<p>3. Education was started on 1-13-16 by the Nurse Educator or designee with licensed staff (RNs, LPNs) on all shifts related to ensuring each new admission accurately identifies the transferring facility, has an accurate admitting diagnosis and a complete admission assessment on all new residents.</p> <p>4. The DON or designee will audit all new admissions during the morning clinical meeting to verify each new admission has a complete and accurate medical record to include the correct transferring facility, accurate admitting diagnosis and a complete admission assessment.</p> <p>Results will be reviewed by QAPI x3 months. Any aberrancies will be addressed, interventions developed and corrective action taken.</p> <p>5. February 6, 2016</p>	02-06-16	

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F 514	Continued From page 6 did not have a fall in the facility, or a history of falls that she was aware of. Interview with the Director of Nursing (DON) on 1/6/15 at 1:00 PM in the DON's office confirmed the facility failed to accurately identify the transferring facility, and failed to have an accurate admission diagnosis on the Nursing Admit/Readmit Information form dated 8/4/15. Continued interview with the DON confirmed the facility failed to complete a Fall Risk Assessment for Resident #96.	F 514			