

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

PRINTED: 03/02/2011
FORM APPROVED
OMB NO. 0938-0391

RECEIVED
MAR 27 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445490	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/01/2011
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NAME OF PROVIDER OR SUPPLIER AVE MARIA HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2605 CHARLES BRYAN RD BARTLETT, TN 38134
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(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
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F 278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>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.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to ensure the required Minimum Data Set (MDS) was completed for 1 of 15 (Resident #2) sampled residents.</p>	F 278	<p>Facility will ensure the assessment accurately reflects the resident's status.</p> <p><u>Plan of Correction:</u> MDS Discharge/Tracking form for Resident #15 has been completed and is now a part of the closed record. All closed records from 12-2010 to present have been reviewed to ensure discharge MDS has been completed.</p> <p><u>Preventative Action:</u> MDS Coordinator re-trained on the completion of MDS discharge form by the DON on 3-14-11. Medical Records Clerk re-trained on ensuring MDS discharge forms are completed when closing records by the DON on 3-14-11</p> <p><u>QA & Monitoring:</u> MDS Coordinator will report to the Quality Assurance Committee for the next two quarters on the compliance of MDS discharge form completion. Based on 100% compliance, quarterly reports to Committee will cease, however, DON, or designee, will continue random audits to ensure compliance.</p> <p><u>Date of Completion:</u></p>	3-15-11
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acceptable POC 3/23/11 of PHNCL

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Debra H. Garden TITLE: *NHA* (X8) DATE: *3-18-11*

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.

This same POC was found 3/18/11 of PHNCL

Date of Completion: 3-31-11

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NAME OF PROVIDER OR SUPPLIER AVE MARIA HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2805 CHARLES BRYAN RD BARTLETT, TN 38134
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F 278	<p>Continued From page 1</p> <p>The findings included:</p> <p>Medical record review for Resident #15 documented an admission date of 5/24/05 with diagnoses of Chronic Pemphegoid, Anemia, Peptic Ulcer Disease, and Osteoarthritis. Review of a physician's telephone order dated 12/4/10 documented, "...d/c [discharge] to FH [funeral home]..." There was no discharge/tracking form MDS in the medical record.</p> <p>During an interview in the conference room on 3/1/11 at 10:35 AM, the MDS Coordinator was asked if there was a discharge MDS. The MDS Coordinator stated, "I couldn't find it, not even in the computer..."</p>	F 278		
F 280 SS=E	<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>	F 280	<p>Facility will ensure comprehensive care plans are developed and periodically reviewed and revised after each assessment.</p> <p><u>Plan of Correction:</u></p> <ol style="list-style-type: none"> 1. Cast and finger foods have been discontinued on care plan. Master diet list was updated to reflect the discontinued finger foods on 3-1-11. 2. Comprehensive care plan for Resident #4 was updated to include individualized activities on 3-1-11. 3. Comprehensive care plan for Resident #7 was updated to include intervention of a heel protector on left foot on 3-1-11. 	

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F 280 Continued From page 2

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, it was determined the facility failed to revise the comprehensive care plan to reflect individualized activities, diet, heel protectors or a cast for 4 of 15 (Residents #2, 4, 7 and 10) sampled residents.

The findings included:

1. Medical record review for Resident #2 documented an admission date of 9/17/10 with diagnoses of Alzheimer's Disease, Depressive Disorder, Hypercholesterolemia, Osteoporosis, Hypertension and Osteoarthritis. Review of a physician's order dated 2/9/11 documented, "... D/C [discontinue] finger foods." Review of the comprehensive care plan dated 10/1/10 documented, "...Keep cast clean and dry, cover during showers... Diet as ordered. Regular diet, NAS [no added salt] with finger foods..." Review of the dietary Form 1095 documented, "...2/9/11... [change] finger foods to Reg [regular] diet..." the care plan was not updated to reflect the cast had been removed and the finger foods had been discontinued.

Observations in the west hall on 2/28/11 at 9:45 AM, revealed Resident #2 wearing tennis shoes on both feet. There was no cast present.

Observations in Resident #2's room on 2/28/11 at 4:20 PM, revealed Resident #2 wearing tennis shoes on both feet. There was no cast present.

During an interview in Resident #2's room on

F 280

4. Comprehensive care plan for Resident #10 was updated to include individualized activities on 3-1-11.

Preventative Action:
Interdisciplinary team will be re-trained on revising comprehensive care plans to reflect individualized activities, diet, heel protector or any other devices/equipment by DON and Administrator on 3-16-11. Interdisciplinary team will review care plans at weekly meetings to ensure they are individualized and comprehensive.

QA & Monitoring:
MDS Coordinator will report to the Quality Assurance Committee for the next two quarters on compliance of individualized and comprehensive care plans in activities, dietary and nursing. Based on compliance, quarterly reports may cease, however, care plans will be randomly monitored by DON and Administrator for any problems.

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F 280	<p>Continued From page 3</p> <p>2/28/11 at 4:20 PM, Nurse #2 confirmed that Resident #2 did not have a cast.</p> <p>During an interview in the conference room on 3/1/11 at 1:53 PM, the Dietary Manager (DM) confirmed the finger foods had been discontinued on Resident #2.</p> <p>2. Medical record review for Resident #4 documented an admission date of 10/20/09 with diagnoses of Alzheimer's Disease, Peripheral Neuropathy, Seizure Disorder, Hypothyroidism, Gout, Cardiovascular Disease and Depression. Review of the annual Minimum Data Set with an assessment reference date of 2/11/10 documented, "...SECTION N... GENERAL ACTIVITY PREFERENCES... d. Music... f. Spiritual/religious activities... h. wheeling outdoors... k. talking or conversing..." Review of the "Activity Progress Notes" dated 2/3/11 documented, Resident #4 participated in and enjoyed the following activities: daily chapel services, family visits, sun porch sitting, pet therapy dog, music, and watching birds from the porch. Review of the comprehensive care plan reviewed 2/2/11 documented, "...Resident requires sensory stimulation and needs met by staff... Resident will be invited / given choice of activities Sensory stimulation with 1: [on] 1 include resident in "bus ride" outing..." The comprehensive care plan did not include the individualized activities enjoyed by the resident.</p> <p>During an interview in the west hall nurses' station on 3/1/11 at 1:20 PM, the Activity Director reviewed the "Activity Progress Notes" dated 2/3/11 and the comprehensive care plan reviewed 2/2/11. The Activity Director stated, "I don't see any of these activities on the care plan..."</p>	F 280		

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F 280	<p>Continued From page 4 [activities] Should be on there."</p> <p>3. Medical record review for Resident #7 documented an admission date of 6/6/03 with diagnoses of Congestive Heart Failure, Episodic Mood Disorder, Orthostatic Hypotension, Abnormal Gait and Affective Psychosis. Review of the comprehensive care plan dated 7/5/10 did not include the intervention of a heel protector on the left foot.</p> <p>Observations in Resident #7's room on 2/27/11 at 10:15 AM and 2:20 PM and on 2/28/11 at 9:45 AM and 2:35 PM, revealed Resident #7 wearing a heel protector on her left foot.</p> <p>Observations in the dining room on 2/28/11 at 7:30 AM and 4:30 PM, revealed Resident #7 wearing a heel protector on her left foot.</p> <p>Observations in the west hall on 3/1/11 at 10:55 AM, revealed Resident #7 wearing a heel protector on her left foot.</p> <p>During an interview in the west hall nurses' station on 3/1/11 at 10:55 AM, Nurse #1 confirmed Resident #7 was wearing a heel protector. Nurse #1 was asked if the heel protector was on the care plan. Nurse #1 stated, "I don't see it [heel protector on the care plan]."</p> <p>4. Medical record review for Resident #10 documented an admission date of 10/6/08 with diagnoses of Alzheimer's Dementia, Delusional Disorder, Depression and Atrial Fibrillation. Review of the annual Minimum Data Set with an assessment reference date of 8/23/10 documented, "...SECTION N... GENERAL ACTIVITY PREFERENCES... d. Music... f.</p>	F 280		

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F 280 Continued From page 5
spiritual/religious activities... h. wheeling outdoors
i. Watching TV... k. Talking or conversing..."
Review of the "Activity Progress Notes" dated
12/1/10 documented Resident #10 participated in
and enjoyed the following activities: small group
or in room visits, therapeutic touch/textured
objects, and the pet therapy dog. Review of the
comprehensive care plan reviewed 2/23/11
documented, "...RESIDENT WILL BE PROVIDED
WITH SENSORY STIMULATION AND
EMOTIONAL SUPPORT THRU [through]
VERBAL / TACTILE STIMULATION... CASUAL
CONVERSATION AND REMINISCE... VISIT
WITH RESIDENT 1:1... USE TOUCH
JUDIOUSLY..." The comprehensive care plan did
not include the individualized activities enjoyed by
the resident.

F 282
SS=D 483.20(k)(3)(ii) SERVICES BY QUALIFIED
PERSONS/PER CARE PLAN

The services provided or arranged by the facility
must be provided by qualified persons in
accordance with each resident's written plan of
care.

This REQUIREMENT is not met as evidenced
by:
Based on medical record review, observation and
interview, it was determined the facility failed to
follow the comprehensive care plan for floor pads
or a tall back cushion for 2 of 15 (Residents #2
and 7) sampled residents.

The findings included:

1. Medical record review for Resident #2
documented an admission date of 9/17/10 with
diagnoses of Alzheimer's Disease, Depressive

F 280

F 282 Facility will ensure that services
provided or arranged by facility
are in accordance with each
resident's plan of care.

Plan of Correction:

1. Direct care staff for Resident #2
on 7/3 and 3/11 shifts 2-27-11
and 2-28-11 have been re-trained
to follow the comprehensive care
plan in providing tall back
cushion while up in chair. CNA
care plan has been reviewed to
ensure it is updated.
2. Direct care staff for Resident #7
on 7/3 and 3/11 shifts on 2-27-11
and 2-28-11 have been re-trained
to follow the comprehensive care
plan in providing floor mats on each
side of bed. CNA care plan has
been reviewed to ensure it is
updated.

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F 282 Continued From page 6
Disorder, Hypercholesterolemia, Osteoporosis, Hypertension and Osteoarthritis. Review of a physician's order dated 2/1/11 documented, "...USE TALL BACK CUSHION WHILE UP... W/C [wheelchair]..." Review of the comprehensive care plan dated 10/1/10 documented, "...use tall back cushion while up in wheelchair for posterior support..."

Observations in the dining room on 2/27/11 at 4:45 PM and on 2/28/11 at 7:40 AM, revealed Resident #2 sitting in the w/c with no tall back cushion in place as care planned.

Observations in the west hall on 2/28/11 at 9:45 AM, revealed Resident #2 sitting in the w/c with no tall back cushion in place as care planned, and Resident #2's head was falling backwards.

Observations in Resident #2's room on 2/28/11 at 4:20 PM, revealed Resident #2 sitting in the w/c with no tall back cushion in place as care planned.

During an interview in Resident #2's room on 2/28/11 at 4:20 PM, Nurse #2 verified that Resident #2 did not have a tall back cushion in the w/c.

2. Medical record review for Resident #7 documented an admission date of 6/6/03 with diagnoses of Congestive Heart Failure, Episodic Mood Disorder, Orthostatic Hypotension, Abnormal Gait, Congestive Heart Failure and Affective Psychosis. Review of the comprehensive care plan dated 7/5/10 documented, "...Low bed with floor pads..."

Observations in Resident #7's room on 2/28/11 at

F 282 Preventative Action:
Nursing staff will be inserviced on providing proper equipment as ordered by physician and documented on care plan. Medical records for residents with devices as tall back cushions and floor pads will be reviewed by DON or designee to ensure all care plans are updated and current. DON or designee will monitor compliance in use of devices.

QA & Monitoring:
DON or designee will randomly monitor and audit for use of devices as ordered by physician and documented on care plan. DON or designee will report on compliance to Quality Assurance Committee through the next two quarters. If there are no compliance issues, reports to the Committee will cease, however, DON or designee will continue to monitor to ensure compliance.

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F 282 Continued From page 7
2:35 PM, revealed Resident #7 lying in bed. There were no floor pads on either side of the bed as care planned.

F 309 SS=D During an interview in Resident #7's room on 3/1/11 at 10:55 AM, Nurse #1 confirmed there was only one floor pad present in the room.
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, observation and interview, it was determined the facility failed to ensure the physician's orders were followed for a diet and a tall back cushion for 1 of 15 (Resident #2) sampled residents.

The findings included:

1. Medical record review for Resident #2 documented an admission date of 9/17/10 with diagnoses of Alzheimer's Disease, Depressive Disorder, Hypercholesterolemia, Osteoporosis, Hypertension and Osteoarthritis. Review of a physician's order dated 2/1/11 documented, "...USE TALL BACK CUSHION WHILE UP... W/C [wheelchair]... REGULAR FINGER FOODS... D/C [discontinue] finger foods..." Review of the comprehensive care plan dated 10/1/10

F 282

F 309 Facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with comprehensive assessment and care plan.

Plan of Correction:
Direct care staff for Resident #2 on 7/3 and 3/11 shifts on 2-27-11 and 2-28-11 have been re-trained to follow the comprehensive care plan in providing tall back cushion while up in chair. Finger foods were discontinued on care plan on 2-9-11. Master diet list was updated to reflect discontinue finger foods and provide Regular, NAS diet on 3-1-11.

Preventative Action:
Nursing staff will be inserviced on providing proper equipment as ordered by physician. Medical records for residents with devices as tall back cushions will be reviewed by DON or designee to ensure equipment is provided for resident's use. Physician orders for all diets will be checked against care plans during weekly

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F 309	<p>Continued From page 8</p> <p>documented, "...use tall back cushion while up in wheelchair for posterior support... Diet as ordered. Regular diet, NAS [no added salt] with finger foods..."</p> <p>Observations in the dining room on 2/27/11 at 4:45 PM and on 2/28/11 at 7:40 AM, revealed Resident #2 sitting in the w/c with no tall back cushion in place as ordered.</p> <p>Observations in the west hall on 2/28/11 at 9:45 AM, revealed Resident #2 sitting in the w/c with no tall back cushion in place as ordered and Resident #2's head was falling backwards.</p> <p>Observations in Resident #2's room on 2/28/11 at 4:20 PM, revealed Resident #2 sitting in the w/c with no tall back cushion in place as ordered.</p> <p>During an interview in Resident #2's room on 2/28/11 at 4:20 PM, Nurse #2 verified that Resident #2 did not have a tall back cushion in the w/c.</p> <p>During an interview in the conference room on 3/1/11 at 1:53 PM, the Dietary Manger (DM) was asked about the physician's order for a regular diet for Resident #2. The DM stated, "...haven't had any communication about changing the no added salt to regular..." The DM verified Resident #2 received a Regular No Added Salt diet.</p>	F 309	<p>Interdisciplinary team meetings as well as the dietary master list to ensure correct diets are provided.</p> <p><u>QA & Monitoring:</u> DON or designee will randomly audit and monitor use of devices/equipment as ordered by physician for the residents. Dietary Director or designee will audit and monitor physician diet orders as they are recorded on master diet list to ensure compliance. DON and Dietary Director will report on compliance to the QA Committee for the next two quarters. Random audits will continue and any issues reported to Administrator and corrected on occurrences.</p> <p><u>Completion Date:</u></p>	3-31-11
F 518 SS=D	<p>483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS</p> <p>The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.</p>	F 518	<p>Facility will train all employees in emergency procedures on hire and periodically review procedures with existing staff. Unannounced staff drills will be carried out using those procedures.</p>	

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F 518 Continued From page 9

This REQUIREMENT is not met as evidenced by:
Based on interviews, it was determined the facility failed to ensure 2 of 4 environmental services staff (EVS #1 and 2) were knowledgeable of the emergency plans.

The findings included:

During an interview in the hallway outside of the laundry room on 2/28/11 at 11:30 AM, EVS #1 was asked what she would do if there was a fire in the laundry. EVS #1 stated, "...Run up the stairs and tell someone..." The surveyor asked where the fire alarm pull station was in the laundry. EVS #1 and EVS #2 were unable to tell the surveyor the location of the fire alarm pull station in the laundry.

During an interview on the west hall at the nurses' station on 2/28/11 at 11:30 AM, the housekeeping supervisor was asked what was expected of the laundry staff during a fire drill. The housekeeping supervisor stated, "Would expect them to pull the alarm."

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Plan of Correction:
EVS #1 and #2 have been re-trained on 3-14-11 and 3-15-11 to ensure they are knowledgeable of fire alarm pull stations.

Preventative Action:
Staff training is done on hire for all departments in emergency procedures. Drills are held throughout the year as required by State and Federal regulations to ensure all staff understand their duties. Fire emergency procedures are currently printed on the back of each employee name tag.

Staff re-training held on 3-12-11 on fire emergency procedures.

QA & Monitoring:
Maintenance/Safety Committee Director will report to Quality Assurance Committee through the next two quarters on initial staff training and results of staff drills. Based on compliance as evidenced by drill results, reporting to QA Committee may cease, however, Maintenance/Safety Director will continue to monitor staff and report any concerns to Administrator.

Date of Completion: 3-15-11

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