

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

RECEIVED

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FORM APPROVED
OMB NO. 0938-0391

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 06/01/2012
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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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<p>F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED SS=D PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>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 follow a care plan intervention for falls for 1 of 13 (Resident #26) sampled residents of the 17 residents included in the Stage 2 review.</p> <p>The findings included:</p> <p>Review of the facility's comprehensive care plan policy documented, "...Care Plan Interventions... Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem area(s), rather than addressing only symptoms or triggers... Interdisciplinary Process... Identifying problem areas and their cause, and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require careful data gathering, proper sequencing of events and complex clinical decision making... Reviewing and Updating... The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans..."</p> <p>Review of the facility's fall risk assessment and prevention program documented, "...Guideline acceptable POC 6/13/12 HP PHWZ</p>	<p>F 282 Facility will continue to follow care plan interventions for falls.</p> <p><u>Plan of Correction:</u> 1. Floor mats have been placed in bedroom of elder #26 for use while elder is in bed.</p> <p>All falls will be addressed in weekly fall meetings to review falls, causative factors and interventions.</p> <p><u>Preventative Action:</u> 2. All care plans for current elders with history of or potential for falls will be reviewed by Director of Nursing or designee and MDS Coordinator to assure fall interventions are being followed.</p> <p>3. Nursing staff will be re-educated on following care plan interventions for falls by the Education Coordinator.</p> <p><u>QA and Monitoring:</u> MDS Coordinator will report to the Quality Assurance Committee for the next two quarters on compliance of fall interventions identified on care plans. Based on compliance quarterly reports may cease, however, care plans will be randomly monitored by DON and Administrator or ADON for any problems.</p> <p><u>Date of Completion:</u> 7-01-2012</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Debra R. Darden</i>	TITLE NHA	(X6) DATE 6-14-12
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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 282	<p>Continued From page 1</p> <p>Protocol ...7. All residents in the Fall Prevention Program are to have their care plan reviewed, interventions updated, and identified on the interdisciplinary care plan... Procedure... 1. All residents, regardless of fall risk scores, are to have interventions and appropriate actions implemented to reduce the risk of and prevent falls... 3. Residents identified as "high risk" for falls are to have additional interventions appropriate to their condition implemented..."</p> <p>Medical record review for Resident #26 documented an admission date of 4/27/12 with diagnoses of Urinary Tract Infection, Acute Mental Status Change, Benign Hypertension, Osteoarthritis and General Muscle Weakness. Review of the fall risk evaluation dated 4/27/12 and 5/8/12 documented, "...INSTRUCTIONS... If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. A prevention protocol should be initiated immediately and documented on the care plan... TOTAL SCORE... 18..." Review of the nurse's notes dated 5/25/12 (date of nurse's note is inaccurate; fall actually occurred on 5/27/12) documented, "...As this writer [Nurse #3] was making rounds found resident lying on floor on right side, ROM [range of motion] intact [intact] c/o [complains of] R [right] shoulder & [and] R hip pain during ROM..." Review of the care plan dated 5/14/12 and updated on 5/27/12 documented, "...5/27/12 Fall... 5/25/12 [date of intervention is inaccurate; intervention developed for fall on 5/27/12] Floor mats to bedside while elder [resident] is in bed..."</p> <p>Observations in Resident #26's room on 5/29/12 at 2:20 PM, on 5/30/12 at 8:00 AM and on</p>	F 282		

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F 282	<p>Continued From page 2</p> <p>5/31/12 at 9:00 AM, revealed no floor mats at Resident #26's bedside or in the room.</p> <p>During an interview in the Resident #26's room on 5/31/12 at 9:00 AM, Certified Nursing Assistant (CNA) #3 confirmed there was no floor mat in Resident #26's room. CNA #3 was asked if floor mats were used for Resident #26 while in bed. CNA #3 stated, "...she has not had a problem with falls on 7- [to] 3 shift... it [floor mat] would still be in the room..."</p> <p>During an interview in Resident #26's room on 5/31/12 at 10:39 AM, the Director of Nursing (DON) was asked about the intervention put in place for Resident #26's fall on 5/27/12. The DON stated, "...Floor mats... they should be in her [Resident #26's] room... it does not appear that they [floor mats] are here [in Resident #26's room]..."</p> <p>During an interview in Resident #26's room on 5/31/12 at 10:50 AM, Nurse #2 confirmed there was no floor mat in Resident #26's room and stated, "...I have not seen any fall mats... it [floor mat] should still be in the room..."</p>	F 282	
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p>	F 441	<p>Facility will continue to maintain infection control practicing to prevent the spread of infection during the passing of ice from hydration cart.</p> <p><u>Plan of Correction:</u> 1. CNA #1 has been re-educated by Education Coordinator to place ice scoop in holder and not in ice cooler.</p>

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F 441	<p>Continued From page 3</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure 1 of 3 certified nursing assistants (CNA #1) maintained infection control practices to prevent the spread of infection during passing ice from the snack/hydration cart.</p> <p>The findings included:</p>	F 441	<p>2. CNA #1 has been re-educated to wash hands between the filling of ice pitcher.</p> <p><u>Preventative Action:</u> 1. Policy specifically detailing how to serve ice water has been reviewed with all nursing staff by Education Coordinator on June 8-9, 2012.</p> <p><u>QA and Monitoring:</u> ADON or DON will randomly monitor the use of hydration cart for proper infection control procedures and report on compliance to the QA Committee through the next two quarters. Reporting shall continue if any compliance issues are found. If not, ADON or DON shall continue to monitor to ensure compliance.</p> <p><u>Date of Completion:</u> 7-01-12</p>	

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F 441	Continued From page 4 Observations on the west hall on 5/31/12 at 7:45 AM, CNA #1 filled resident's water pitchers with ice from the snack/hydration cart. CNA #1 entered Rooms #107, 109, 110, 111, 112, 113 and 114, picked up the water pitcher, took the pitcher to the hydration cart, removed the ice scoop from the cooler and filled each resident's water pitcher with ice. CNA #1 then placed the ice scoop back in the cooler and closed the lid. CNA #1 used her bare hands and did not wash her hands. During an interview in the conference room on 6/1/12 at 7:05 AM, the Nurse Educator was asked what her expectations were when staff passed ice from the snack/hydration cart. The Nurse Educator stated, "Staff should wash their hands between residents and should place the ice scoop outside the cooler in the scoop container."	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. 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.	F 514	Facility will continue to maintain clinical records that are complete, accurate, accessible and organized. <u>Plan of Correction:</u> 1. Elder #51, physician recertification orders dated 5/01/12 have been corrected. 2. Nursing staff will be re-educated on accurate recording and updating clinical records by the ADON and Director of Nursing.	

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F 514	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record review, observation and interview, it was determined the facility failed to have accurate medical records related to physician orders for 1 of 13 (Resident #51) sampled residents of the 17 residents included in the Stage 2 review.</p> <p>The findings included:</p> <p>Medical record review for Resident #51 documented an admission date of 2/12/08 with diagnoses of Alzheimer's, Hypertension, Adult Failure to Thrive, Diabetes, Osteoarthritis, Hyperlipidemia, Anemia, Angiopathy, Debility, Chronic Kidney Disease and Muscle Weakness. Review of a physician's telephone order dated 4/17/12 documented, "...D/C [discontinue] Lap tray [and] use weighted blanket..." Review of the physician's recertification orders dated 5/1/12 documented, "...GERI CHAIR LAP TRAY FOR PROPER POSITIONING TO PREVENT SLIDING WHILE UP IN GERI CHAIR, CHECK EVERY 30 MINUTES REMOVE & [and] REPOSITION EVERY 2 HRS [hours]..."</p> <p>Observations in the living room in the St. Joseph House on 5/29/12 at 10:30 AM, revealed Resident #51 seated in a reclined gerichair without a lap tray.</p> <p>Observations in the dining room in the St. Joseph House on 5/30/12 at 8:05 AM and on 5/31/12 at 8:00 AM, revealed Resident #51 seated in a reclined gerichair without a lap tray.</p> <p>During an interview in the conference room on</p>	F 514	<p><u>QA and Monitoring:</u></p> <p>The DON and ADON will randomly review clinical records to ensure records are complete, accurate, easily accessible and organized. The ADON or DON will report to the Quality Assurance Committee for the next 2 quarters on compliance of clinical record keeping.</p> <p><u>Date of Completion:</u> 7/01/12</p>	7/01/12

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F 514	Continued From page 6 6/1/12 at 8:30 AM, the Director of Nursing (DON) confirmed the recertification orders were inaccurate. The DON stated, "When the nurse checked the orders, she should have marked through that [order for the lap tray], she failed to do that..."	F 514	