

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

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PRINTED: 02/01/2016
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 _____ FEB 11 2016	(X3) DATE SURVEY COMPLETED 01/21/2016
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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 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, the facility failed to ensure behaviors was coded accurately on the Minimum Data Set (MDS) for 1 of 18 (Resident #53) sampled residents of the 34 residents included in the stage 2 review.</p> <p><i>acceptable POC 2/10/16 JPPHALL</i></p>	F 278	<ol style="list-style-type: none"> 1. An MDS Assessment was completed on Resident #53 to accurately reflect the resident's status. 2. An in-service was conducted by the Director of Nurses (DON) with the MDS nurses and interdisciplinary team regarding completing the MDS accurately. 3. All residents MDS assessments will be reviewed to ensure they accurately reflect the resident status. 4. Prior to transmission, the DON will monitor 3 random MDS assessments for accuracy and review any errors noted with the specific member of the interdisciplinary team. 5. Results of the monitoring by the DON will be discussed in the quarterly CQI and subsequent plans of correction will be implemented as necessary. <p>Date of Correction 2/22/16</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Marlene Siegel* TITLE *Administrator* (X6) DATE *2-10-16*

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 278	<p>Continued From page 1</p> <p>The findings included:</p> <p>Medical record review revealed Resident #53 was admitted to the facility on 3/10/14 and readmitted on 10/5/15 with diagnoses of Cerebral Infarction, Respiratory Failure, Dysphagia, Hemiplegia, Vascular Dementia, Hypercholesterolemia, Diabetes Mellitus, Hypertension, Edema, Osteoarthritis and Atherosclerosis of the Aorta.</p> <p>The 90 day MDS with an Assessment Reference Date (ARD) of 1/13/16 documented behavior of delirium and inattention continuously present, and physical behavioral symptoms directed towards others.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 1/21/16 at 10:57 AM, in the conference room, LPN #2 was asked to describe Resident #53's behaviors. LPN #2 stated, "He did have behaviors at one time but he had a stroke and when he returned, he no longer exhibited those behaviors. He went out on 9/30/15 and returned 10/5/15."</p> <p>Interview with the MDS Coordinator on 1/21/16 at 12:10 PM, in the conference room, the MDS Coordinator was asked if there was any documentation that behaviors were exhibited by Resident #53. The MDS Coordinator stated, "There's not anything documented. It's just typographical [error]." The MDS Coordinator was asked if the 1/2/16 was accurate. The MDS Coordinator stated, "Maybe it's just an honest mistake, as far as I know it's not accurate."</p> <p>Interview with the MDS Coordinator on 1/21/16 at 3:00 PM, in the MDS office, was asked where the information for coding the MDS was obtained. The MDS Coordinator stated, "Social Services</p>	F 278		

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F 278	Continued From page 2 completes the behavior part of the MDS on paper and the MDS coordinators put the information in. She [Social Services] marked zero behaviors so I don't know why the resident was coded with behaviors."	F 278		
F 431 SS=D	<p>The MDS was not accurate for behaviors. 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>	F 431	<ol style="list-style-type: none"> 1. Each medication room and cart was inspected for outdated drugs. 2. An in-service will be conducted by the Director of Staff Development with the licensed nurses regarding medication administration with a focus on outdated drugs. 3. Discontinued and outdated drugs will be placed in the pharmacy bin located on the West Hall in the medication room by the licensed nurse. 4. The Director of Nurses (DON) or designee will randomly monitor each medication cart and the medication room on the West Hall and in each Green House room for the storage of current dated drugs and biologicals. 5. The pharmacy consultant will inspect each medication room on the West Hall and wallaroos in the Green House homes to ensure the expiration date is current for all drugs and biologicals. 6. Results of monitoring by the DON and pharmacy consultant will be discussed in the quarterly CQI meeting and subsequent plans of correction 	

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F 431	<p>Continued From page 3</p> <p>package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, the facility failed to ensure medications were not stored past their expiration/use by dates in 2 of 8 (Greenhouse 1 and West hall split cart) storage areas.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility's medication storage policy documented, "...The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed..." 2. Observations in Greenhouse 1 medication room, on 1/20/16 at 2:30 PM, revealed the following: <ol style="list-style-type: none"> a. A bottle of Oyster Shell 500 milligrams (mgs) stored past the expiration date of 12/15. b. A bottle of Docusate Sodium 100 mg stored past the expiration date of 11/15. c. A bottle of Oyster Shell 500 mg with Vitamin D stored past the expiration date of 11/14. 3. Review of the Med-Pass "Diabetes: Injectable Medications" policy documented, "...Humulin R [regular]... Once opened, refrigerated or not, product must be used within 31 days..." <p>Observations on the West hall split medication cart, on 1/21/16 at 11:30 AM, revealed Novolin R insulin with an opened date of 12/10/15. The</p>	F 431	<p>will be implemented as necessary.</p> <p style="text-align: right;">Date of Compliance</p>	2/22/16

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F 431	Continued From page 4 insulin was not discarded within 31 days of being opened. Interview with Licensed Practical Nurse (LPN) #2 at the West hall split medication cart, on 1/21/16 at 11:35 AM, LPN #2 was asked how long is Novolin Regular insulin good for if it is opened on 12/10/15. LPN #2 stated, "28 days". LPN #2 was asked if the Novolin R with an open date of 12/10/15 was still good. LPN #2 stated, "No." Interview with the Director of Nursing (DON) outside the conference room, on 1/21/16 at 11:45 AM, the DON was asked how long regular insulin is good. The DON stated, "28 to 30 days." The DON was asked if regular insulin has an open date of 12/10/15, should the insulin be administered after that date. The DON stated, "No. It's beyond the date it is to be used."	F 431			
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.	F 497	Corrective Action Reports were issued to all eight (8) Certified Nurses Assistants (CNA) who failed to complete the 2015 required in-service hours. The Director of Staff Development will in-service staff monthly. On 1/29/16, Ave Maria Home, Inc. purchased a computer generated in-service training program that will maintain accurate tracking of in-service education earned by each staff member employed at Ave Maria Nursing Home, Inc. As of 1/29/16, all staff names have been entered into the tracking log on Health Care		

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F 497	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on review of Certified Nursing Assistants (CNA) in-service attendance records for 2015, and interview, the facility failed to ensure 8 of 46 (CNAs #1, 2, 3, 4, 5, 6, 7 and 8) CNAs employed the entire year of 2015 received at least 12 hours of in-service training.</p> <p>The findings included: Review of the CNA in-service attendance records documented the following CNA in-service hours for 2015:</p> <ul style="list-style-type: none"> a. CNA #1 - with a date of hire 9/01/14 had a total of 5 hours. b. CNA #2 - with a date of hire 9/26/14 had a total of 9 hours. c. CNA #3 - with a date of hire 10/27/04 had a total of 9 hours. d. CNA #4 - with date of hire 11/20/12 had a total of 8.5 hours. e. CNA #5 - with a date of hire 5/14/12 had a total of 8.5 hours. f. CNA #6 - with a date of hire 4/05/11 had a total of 10 hours. g. CNA #7 - with a date of hire 9/8/14 had a total of 10.5 hours. h. CNA #8 - with a date of hire 9/11/07 had a total of 8 hours. <p>Interview with the Administrator on 1/21/16 at 3:17 PM, in the conference room, the Administrator was asked about the in-service hours for these 8 CNAs. The Administrator stated, "We have had several staffing coordinators and this [CNA in-services] fell through the cracks."</p>	F 497	<p>Academy and documentation will be entered as of this date for in-service education credit earned by each staff person.</p> <p>The Director of Staff Development will be responsible for the entry of data on the in-service tracking log for each CNA after each in-service is attended by the CNA.</p> <p>The tracking log will be reviewed quarterly by the Director of Nurses or designee to ensure that CNAs are acquiring required in-service hours in a timely manner.</p> <p>Results of the monitoring will be discussed in the quarterly CQI by the Director of Staff Development and subsequent plans of correction will be implemented as necessary.</p> <p style="text-align: right;">Date of Correction</p>	2/22/16	

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