

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

RECEIVED

PRINTED: 12/28/2009  
FORM APPROVED  
OMB NO. 0938-0391

JAN 15 2010

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  12/22/2009
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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 280 SS=D 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS

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.

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.

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 plan of care to reflect the resident's current status for wheelchair, anti-tippers and/or refusing supplements for 2 of 16 (Residents #1 and #10) sampled residents.

The findings included:  
1. Medical record review for Resident #1 documented an admission date of 11/10/06 with diagnoses of Status Post Hip Fractures, Alzheimer's Dementia, Osteoporosis, Arthritis and

F 280 Ave Maria Home will continue to 1-14-10 revise the plan of care to reflect the resident's current status.

The care plan for Resident #1 was revised on 1/12/10 to reflect that Resident #1 will be offered an alternative to the nutritional supplement of equal nutritional value if desired at meal time when she doesn't drink the nutritional supplement ordered by her physician. The weight loss committee members will meet monthly and discuss trends noted by nursing staff at monthly weight loss meetings to ensure that the majority of residents receiving a nutritional supplement favor the taste of the nutritional supplement purchased by the facility. The Dietary Manager (DM), or her designee, will alert the charge nurse for each resident when a trend is noted that a resident is unwilling to drink the nutritional supplement ordered by the physician at mealtime. After being informed by the DM, or her designee, of the above noted information, the charge nurse will contact the resident's physician for additional dietary orders. The DON, or her designee, will monitor residents receiving a nutritional supplement to ensure that the physician is alerted timely when a resident does not accept a nutritional supplement as ordered.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Frank J. [Signature]* TITLE: *acceptable ROC 1/26/10 SP PH NLR Administrator* (X9) DATE: *1/13/10*

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 Continued From page 1

Hypertension. A physician's order signed 12/1/09 documented, "4oz [ounces] 2 cal [calorie] shake w/ [with] lunch & [and] dinner meals." The care plan dated 11/16/09 documented, "4 oz 2cal shake c [with] just reward ice cream L/D [lunch and dinner] meals."

Observations in the dining room on 12/21/09 at 12:40 PM and 5:13 PM, revealed Resident #1 was eating her meal and had no shake on her tray was present.

During an interview in the kitchen on 12/22/09 at 10:10 AM, the Dietary Manager (DM) stated the patient does not like the shakes and will get agitated when offered one, therefore the staff will remove the shake from her table. The DM stated the Registered Dietitian will be in soon and an alternative will be discussed with her.

Resident #1's care plan was not revised to reflect the resident's refusal of the 2 cal shake or that alternatives were to be offered.

2. Medical record review for Resident #10 documented an admission date of 9/11/08 with diagnoses of Dementia, Failure To Thrive, Hypertension, Alzheimer's, General Osteoarthritis, Osteoporosis and End Stage Alzheimer's. A physician's order dated 10/5/09 documented "D/C [discontinue] use of w/c [wheelchair]..." The care plan dated 11/25/09 documented, "...Antitippers to WC [wheelchair]..."

Observations in the dining room on 12/21/09 at 5:00 PM and on 12/22/09 at 8:03 AM, revealed Resident #10 seated in a gerichair with a tray.

During an interview in the conference room on

F 280 Resident #10's care plan was revised on 12/30/09 to reflect the discontinuation of anti tippers on the resident's wheelchair. The Minimum Data Set (MDS) nurse will review care plans weekly to ensure that resident care plans accurately reflect the care and services ordered for each resident. On 12/30/09, in-service education was provided by the Director of Nurses (DON) to all members of the Interdisciplinary Team on the importance of the care plan being accurately reviewed and revised. The Assistant Administrator (AA) and the DON will be responsible for the review of ten percent (10%) of the facility care plans monthly to ensure that care plan information is updated accurately and timely.

The findings of the monthly monitoring regarding supplements will be discussed at monthly Weight Loss Continuous Quality Improvement (CQI) meetings and the findings reported by the DM to the Executive Director (ED). The DON will report care plan audits to the ED at quarterly CQI meetings.

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F 280	Continued From page 2 12/22/09 at 2:35 PM, the Director of Nursing stated, "...should [the antitippers] have been d/c'd [discontinued] with the w/c..."  Resident #10's care plan was not updated to reflect the use of the w/c and antitippers had been discontinued.	F309	Ave Maria will continue to ensure physician orders are obtained and followed.  The Physician Order (PO) for Resident #2 was obtained on 1/11/10 to indicate the provider of Hospice services ordered by the resident's physician. As of 1/12/10, the RN Supervisor will audit the other seven (7) charts for residents on Hospice to ensure that the Hospice organization is identified on the resident's current PO. The third shift charge nurse will check all orders to ensure that accurate information is documented on the monthly Re-Certification Physician Order (PO) for each resident.	1-14-10
F 309 SS=D	483.25 QUALITY OF CARE  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 physician's orders were obtained or followed for hospice care, removal of slide buckle belt and/or lap buddy for 3 of 16 (Residents #2, 8 and 10) sampled residents.  The findings included:  1. Medical record review for Resident #2 documented an admission date of 8/27/09 with diagnoses of Dementia, and End Stage (E/S) Alzheimer's Disease. A physician's telephone order dated 8/27/09 documented "Continue c [with] [named hospice company] Hospice c diagnosis of E/S Dementia..." Review of a current physician's order dated 12/1/09 did not include an order for hospice care.	F 309	Resident #8 and every other resident seated in a wheelchair with a slide buckle restraint will have their restraint removed at meal time if ordered by the resident's physician to remove the restraint at meal time. On 12/27/09 and 12/28/09, the DON provided in-service education to certified and licensed nursing staff members regarding the importance of following physician orders (i.e., -to remove a restraint at meal time if ordered by the resident's physician to do so.) As of 1/13/10, the MDS nurse will review the physician orders and care plan for each resident seated in a wheelchair with a slide buckle belt restraint to ensure that the care plan reflects the Physician's orders. The DON and licensed nurses will monitor the residents seated in a	

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F 309	<p>Continued From page 3</p> <p>During an interview in the conference room on 12/22/09 at 2:42 PM, the Director of Nursing stated, "...[Hospice care] was not transcribed [to current orders] by the pharmacy..."</p> <p>2. Medical record review for Resident #8 documented an admission date of 10/6/08 with diagnoses of Encephalopathy, Dementia, Atrial Fibrillation, Hypertension and Organic Delusional Disorder. A physician's order dated 12/1/09 documented "...slide buckle belt removed @ [at] meals and Q2H [every 2 hours]..."</p> <p>Observations in the restorative dining room on 12/21/09 beginning at 5:10 PM and on 12/22/09 beginning at 8:15 AM, revealed Resident #8 was sitting in the wheelchair (w/c) with a slide buckle belt attached to the w/c.</p> <p>During an interview in the restorative dining room on 12/22/09 at 8:28 AM, Certified Nursing Assistant (CNA) #1 confirmed Resident #8 had a belt intact during breakfast.</p> <p>3. Medical record review for Resident #10 documented an admission date of 9/11/08 with diagnoses of Dementia, Failure To Thrive, Hypertension, Alzheimer's, General Osteoarthritis, Osteoporosis and End Stage Alzheimer's. A physician's order dated 10/5/09 documented "D/C [discontinue] use of w/c... use gerichair when OOB [out of bed] c gerichair tray..." Review of a physician's order dated 12/1/09 documented "...Lap buddy to prevent unassisted ambulation..."</p> <p>Observations in the dining room on 12/21/09 beginning at 5:00 PM revealed Resident #10 was sitting in a gerichair with tray in place.</p>	F 309	<p>wheelchair with a restraint while in the dining room to ensure that restraints are being removed at meal time if the restraint is ordered to be removed by the resident's physician at meal time.</p> <p>On 12/30/09, a PO to discontinue the use of a wheelchair with lap buddy was faxed to the pharmacy for Resident #10. The DON, or her designee, will randomly monitor the accuracy of physician orders weekly to ensure that physician orders are being accurately transcribed on the monthly Re-certifications Physician Orders.</p>	
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F 309	Continued From page 4  Observations in Resident #10's room on 12/22/09 at 7:35 AM and 10:00 AM revealed Resident #10 sitting in a gerichair with tray in place.  During an interview in the conference room on 12/22/09 at 2:35 PM the Director of Nursing stated, "...[lap buddy] should have been d/c'd with the w/c..."	F 309		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to ensure interventions were put in place after each fall for 1 of 6 (Resident #8) sampled residents.  The findings included:  Medical record review for Resident #8 documented an admission date of 10/6/08 with diagnoses of Encephalopathy, Dementia, Atrial Fibrillation, Hypertension and Organic Delusional Disorder. A nurse's note dated 4/18/09 at 11:30 AM documented, "Resident found by family member in w/c [wheelchair]. Resident had slipped under Quick release belt et [and] was up to her kneck [neck]..." There was no intervention documented as being put in place after this	F 323	Ave Maria will continue to ensure interventions are put in place after each fall by a resident.  The medical record for Resident #8 was reviewed by the DON and Assistant Administrator (AA) on 12/22/09. The facility documentation in the medical record reflects an occupational therapy consult ordered as an intervention following the 4/18/09 nursing entry. The Occupational Therapist evaluated positioning for Resident #8 on 4/21/09 and made the following recommendations that were ordered by the attending physician: "Patient to use wedge, pommel cushion to prevent sliding out of wheelchair." The suggested interventions were added to the resident's wheelchair for positioning enhancement. The care plan was revised on 12/16/09 to reflect the interventions recommended by the Occupational Therapist.  On 1/12/10, the DON presented in-service education to the	1/14/10

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F 309 Continued From page 4

Observations in Resident #10's room on 12/22/09 at 7:35 AM and 10:00 AM revealed Resident #10 sitting in a gerichair with tray in place.

During an interview in the conference room on 12/22/09 at 2:35 PM the Director of Nursing stated, "...[lap buddy] should have been d/c'd with the w/c..."

F 323 483.25(h) ACCIDENTS AND SUPERVISION  
SS=D

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:  
Based on medical record review and interview, it was determined the facility failed to ensure interventions were put in place after each fall for 1 of 6 (Resident #8) sampled residents.

The findings included:

Medical record review for Resident #8 documented an admission date of 10/6/08 with diagnoses of Encephalopathy, Dementia, Atrial Fibrillation, Hypertension and Organic Delusional Disorder. A nurse's note dated 4/18/09 at 11:30 AM documented, "Resident found by family member in w/c [wheelchair]. Resident had slipped under Quick release belt et [and] was up to her neck [neck]..." There was no intervention documented as being put in place after this

F 323 licensed nursing staff on the importance of accurate and timely nursing documentation, the necessity of writing information about resident issues on the Nursing Report Log, and the importance of informing each resident's physician of potential safety issues. The DON, or her designee, will review the Nursing Report Log every morning and periodically each shift to ensure that nursing intervention is timely.

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F 323 Continued From page 5 incident on 4/18/09.

During an interview in the conference room on 12/22/09 at 2:48 PM, the Director of Nursing confirmed there was no new intervention put in place after the incident.

F 514 483.75(l)(1) CLINICAL RECORDS  
SS=D

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.

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 clinical records were accurate for Abduction (ABD) pillows, chair alarms and/or physician's orders for 2 of 16 (Residents #1 and 9) sampled residents.

The findings included:

1. Medical record review for Resident #1 documented an admission date of 11/10/06 with diagnoses of Status Post Hip Fractures, Alzheimer's Dementia, Osteoporosis, Arthritis and Hypertension. Review of the physician's order dated 12/1/09 documented, "ABD PILLOW IN

F 323

F 514 Ave Maria will continue to ensure 1/14/10 clinical records are accurate.

The plan of care for Resident #1 was reviewed and revised by the Interdisciplinary team (IDT) on 12/22/09 to reflect the current plan of care for the resident. A physician order was obtained on 12/22/09 to discontinue the use of a tab alert and abduction pillow in the wheelchair for Resident #1.

On 12/27/09 and 12/28/09, the DON provided in-service education to all licensed nursing personnel regarding the importance of accurately reviewing and correcting monthly Physician Orders against the prior month's Physician Orders before placing the upcoming Monthly Re-Certification Physician Orders in a resident's medical record.

On January 12, 2010, the Executive Director (ED) contacted the pharmacy consultant and requested that the transcript staff transcribe orders accurately when the pharmacy receives the copy of a physician order to discontinue or add a service. To prevent this type of transcription

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F 514	<p>Continued From page 6</p> <p>BED &amp; [AND] W/C [WHEELCHAIR]. TAB ALARM WHEN IN BED &amp; W/C TO ALERT STAFF OF UNASSISTED AMBULATION."</p> <p>Observations in the dining room and hallway on 12/21/09 at 12:40 PM, 1:20 PM, 5:13 PM and in the dining room on 12/22/09 at 7:55 AM revealed Resident #1 in a w/c and there was no Tab alarm or ABD pillow present.</p> <p>During an interview in the hallway on 12/22/09 at 9:30 AM, Licensed Practical Nurse #1 stated, "I think the tabs alarm was d/c'd [discontinued] when the slide buckle was added. She's [Resident #1] not got an ABD pillow. She had a fracture back in the summer."</p> <p>2. Medical record review for Resident #9 documented an admission date of 10/19/06 with diagnoses of Subdural Hematoma, Hypertension, Dementia, Anemia and Depression. Review of the physician's orders dated 11/11/09 documented, "D/C O.T. [Occupational Therapy] services..." Review of the current recertification orders signed 12/1/09 documented, "OT 3X [3 TIMES] WK [WEEK] X [FOR] 30 DAYS."</p> <p>During an interview in the conference room on 12/22/09 at 1:30 PM, the Director of Nursing stated, "That's pharmacy transcription [error]. OT should not be on there [the orders]."</p>	F 514	<p>error in the future, the DON will monitor trends for orders being incorrectly transcribed and report her findings to the ED weekly or as trends are noted. Once informed of any negative trends in the Monthly Re-Certification of Physician Orders, the ED will report the trends noted to the consultant pharmacist and pharmacy director for follow-up. The pharmacy consultant will track the trends of transcription errors reported to her by the ED and submit a plan for correction to the ED at quarterly CQI meetings with a goal of 100% compliance in the reduction of transcription errors by the pharmacy transcription department.</p>