

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

PRINTED: 05/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/30/2013
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NAME OF PROVIDER OR SUPPLIER BELCOURT TERRACE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 BELCOURT AVENUE NASHVILLE, TN 37212
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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 323 SS=E	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 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint investigation for TN00031299 Based on policy review, review of facility investigations, medical record review and interview, it was determined the facility failed to implement new interventions after each fall for 3 of 4 (Residents #1, #5, and #6) sampled residents identified with falls. The findings included: 1. Review of the facility's "Fall Prevention Program" policy documented, "...when a resident is found on the floor, the facility is obligated to investigate and try to determine how he/she got there, and to put into place an intervention to prevent this from happening again..." 2. Medical record review for Resident #1 documented an admission date of 02/08/13 with diagnoses of Osteoporosis, Hypertension, Depression, Chronic Obstructive Pulmonary Disease, Irritable Bowel Syndrome, Dementia and Chronic Pain. Review of the care plan dated 2/11/13 documented a problem of "at risk for <i>acceptable PDL 5/9/13 JPR/PHN/A</i>	F 323	Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law. The plan of correction constitutes our credible allegation of compliance	
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STORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Paul M. K...</i>	TITLE Administrator	(X6) DATE 05/07/13
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Deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 participation.

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NAME OF PROVIDER OR SUPPLIER WILLCOURT TERRACE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 BELCOURT AVENUE NASHVILLE, TN 37212
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323	<p>Continued From page 1</p> <p>falls." The approach included, "verbal reminders not to assist independent transfers."</p> <p>Review of the facility's conclusions for investigations of falls were documented as followed:</p> <p>a. 2/12/13 - "instructed by the charge nurse to use her call light for assistance prior to getting up."</p> <p>b. 2/23/13 - "The resident is encouraged to not self transfer and call for assistance. The resident was encouraged not to turn off her alarms."</p> <p>Review of Resident #1's progress notes documented the following:</p> <p>a. 3/17/13 - "...Resident fell on the floor from bed at 1:05 AM... Encouraged patient to verbalize needs and use call light..."</p> <p>b. 3/20/13 - "Resident was found to be on the floor at the beginning of the night shift... Resident encouraged to ask for assistance when needing the potty chair or the toilet. This Nurse also asked resident to please stop turning the alarms off..."</p> <p>c. 3/22/13 - "Pt [patient] found sitting on floormatress, [floor mat] vs [vital signs] stable, pt states that while she was using her bedside commode she loste [lost] her balance..."</p> <p>The facility was unable to provide documentation that new interventions were implemented after Resident #1's falls on 3/17/13, 3/20/13 and 3/22/13.</p> <p>During an interview in the Social Service office on 4/30/13 at 2:20 PM, the Assistant Director of Nursing (ADON) was asked about new interventions implemented after the three falls noted above. The ADON stated, "No new interventions [implemented after the falls on</p>	F 323	<p>Resident #1 is no longer in the facility.</p> <p>Resident #5's and #6's Fall Risk care plans have been reviewed and interventions revised.</p> <p>Residents' care plans have been reviewed for fall risk interventions and revised where needed.</p> <p>Licensed nurses have been reeducated on the fall prevention program, assessing residents post fall for possible new interventions and updating care plans.</p>	
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F 323	<p>Continued From page 2 3/17/13, 3/20/13 and 3/22/13]."</p> <p>3. Medical record review for Resident #5 documented an admission date of 10/3/11 with a readmission date of 1/1/12 with diagnoses of Cellulitis, Gastro Esophageal Reflux Disease (GERD), Anemia, Depression, Chronic Pain, Irritable Bowel Syndrome, Anxiety, Psychosis, Constipation, Multiple Sclerosis (MS), Cardiovascular Disease, and Percutaneous Endoscopy Gastrostomy Tube. Review of the care plan dated 10/3/11 documented a problem of "Risk for falls r/t [related to] Hx [history] of falls, MS..." The approach included "...INFORM RESIDENT OF LOCATION OF CALL LIGHT AND TO USE CALL LIGHT FOR ANY ASSISTANCE NEEDED." Review of the progress note dated 1/13/13 documented "...resident sitting upright on the floor beside the bed... counseled resident to please press her call light and ask for assistance in the future..."</p> <p>Review of the facility's investigation of the fall occurring on 1/13/13 documented a conclusion of "Resident instructed to call for assist before attempting to get up..." The facility was unable to provide documentation of a new intervention implemented to prevent further falls after the 1/13/13 fall.</p> <p>4. Medical record review for Resident #6 documented an admission date of 8/18/11 with diagnoses of Weight Loss, Herpes Zoster, Gout, Neuropathy, Depression, Cardiovascular Disease, Congestive Failure, Hypertension, GERD, Hyperlipidemia, Pain, Acute Myocardial Infarction Inferior Wall, Anemia, Difficulty in Walking, Ischemic Heart Disease. Review of the</p>	F 323	<p>The Director of Nursing, Assistant Director of Nursing and/or designee will complete random audits of residents falls with care plans interventions weekly for 2 months, then quarterly for 3 quarters. Results of the audits will be reviewed in the Quality Assurance meetings for revisions as needed.</p> <p>Completion date: May 7, 2013.</p>	
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F 323	<p>Continued From page 3</p> <p>care plan dated 8/19/11 documented a problem of "Risk for falls r/t HX OF FALLS..." The approach included "...USE CALL LIGHT FOR ANY ASSISTANCE..."</p> <p>Review of the facility's investigation of the fall occurring on 3/1/13 documented a conclusion of "Was isolated incident. No new intervention required at this time."</p> <p>During an interview in the Social Service office on 4/30/13 at 1:15 PM, the ADON was asked if a new intervention should be documented after each fall. The ADON stated, "Yes."</p> <p>During an interview in the Social Service office on 4/30/13 at 2:20 PM, Nurse #1 stated, "New interventions need to be on the care plan, bottom line." The ADON agreed with Nurse #1's response.</p>	F 323		
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