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HEALTH CARE FACILITY

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FORM APPROVED

OK 3/11/12

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7501	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/26/2012
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NAME OF PROVIDER OR SUPPLIER ADAMSPLACE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1927 MEMORIAL BOULEVARD MURFREESBORO, TN 37129
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N 000	Initial Comments Amended Statement of Deficiencies. Complaint pertained to Licensed Only Beds. During complaint investigation of #TN00029189, conducted on January 25 - 26, 2012 deficiencies were cited in relation to the complaint under 1200-8-6, Standards for Nursing Homes	N 000	The Plan of Correction is submitted as required under State and Federal Law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct.	
N 669	1200-8-6-.06(4)(c)4. Basic Services (4) Nursing Services. (c) The Director of Nursing shall have the following responsibilities: 4. Notify the resident's physician when medically indicated. This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to notify the physician of a bruise of unknown origin when discovered for one resident (#2) of five residents reviewed. The findings included: Medical record review revealed resident #2 was admitted to the facility on June 15, 2010, with diagnoses to include Alzheimer's Dementia, Parkinsonism, Hypertension, Osteoarthritis, Gastroesophageal Reflux Disease, Diabetes Mellitus, Breast Cancer, and Colon Cancer. Review of an assessment dated December 26, 2011, revealed the resident had a Brief Interview of Mental Status score of 7 of a possible score of	N 669	The RN assessed the resident's bruise on 1/13/12 and began to investigate the cause of the bruise. The NP was notified of the bruise on 1/20/12. The investigation of the incident was continued on 1/20/12 under the direction of the Director of Nursing. A skin assessment was completed on all patients by 1/31/12 to evaluate condition of patients' skin. Under the direction of the Director of Nursing in-services were held for all licensed nurses on 1/31/12 regarding the center's policy for reporting a bruise of unknown origin which includes notification of the MD/NP in a timely manner.	

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]
Administrator

TITLE

(X8) DATE

2/9/12

STATE FORM

0320

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If continuation sheet 1 of 4

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N 669	Continued From page 1 15 (15 is most cognitive); required assistance with transfers, dressing, bathing, grooming, and eating; was occasionally incontinent of bowel and bladder. Review of physician's notes revealed an entry dated January 20, 2012, in which the Nurse Practitioner wrote "...Pt. (patient) states sat down hard approx. (approximately) 1 wk (week) ago and cannot recall other details. Examined area found approx 1" diameter bruise to upper coccyx and 3-4" bruise to (L) (left) inner buttocks. Area soft to touch, pt. denies pain or tenderness. Contusion etiology unknown." Continued review of physician's notes dated January 24, 2012, the Nurse Practitioner documented "...f/u (follow-up) on sacral contusion. Has faded quite a bit and would expect it to resolve in next 2-3 days". Review of nursing notes from January 1, 2012 to January 24, 2012, revealed no documentation of the occurrence of the bruise and no documentation the physician was notified of the bruise when it occurred. During interview on January 24, 2012, at 1:40 p.m., in the private dining room, the Director of Nursing confirmed the physician was not timely notified of the occurrence of a bruise of unknown origin.	N 669	Director of Nursing will ensure the center's compliance with notification to MD/NP of a patient with a bruise through the quality assurance process. Under the direction of the Director of Nursing, a monitor will be completed monthly X 3 then periodically thereafter to ensure continued compliance. These audit findings will be reported to the quality assurance committee consisting of the Medical Director, Director of Nursing, Administrator and at least two other members of the health care center staff as requested by the quality assurance committee. The quality assurance studies and in-service training will be continued as determined by the Director of Nursing and/or as directed by the quality assurance committee.	2/9/12	
N 779	1200-8-6-.06(10)(a) Basic Services (10) Social Work Services. (a) Social services must be available to the resident, the resident's family and other persons significant to the resident, in order to facilitate adjustment of these individuals to the impact of illness and to promote maximum benefits from	N 779			

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N 779	<p>Continued From page 2</p> <p>the health care services provided.</p> <p>This Rule is not met as evidenced by: Based on medical record review, facility investigation review, and interview, the facility failed to ensure Social Services aided in the investigation of an injury of unknown origin and failed to ensure Social Services interacted with the resident's family for one (#2) of five residents reviewed.</p> <p>The findings included:</p> <p>Medical record review revealed resident #2 was admitted to the facility on June 15, 2010, with diagnoses to include Alzheimer's Dementia, Parkinsonism, Hypertension, Osteoarthritis, Gastroesophageal Reflux Disease, Diabetes Mellitus, Breast Cancer, and Colon Cancer.</p> <p>Review of an assessment dated December 26, 2011, revealed the resident had a Brief Interview of Mental Status score of 7 of a possible score of 15; required assistance with transfers, dressing, bathing, grooming, and eating; was occasionally incontinent of bowel and bladder.</p> <p>Review of physician's notes revealed an entry dated January 20, 2012, in which the Nurse Practitioner wrote "...Pt. (patient) states sat down hard approx. (approximately) 1 wk (week) ago and cannot recall other details. Examined area found approx 1" diameter bruise to upper coccyx and 3-4" bruise to (L) (left) inner buttocks. Area soft to touch, pt. denies pain or tenderness. Contusion etiology unknown." Continued review of physician's notes dated January 24, 2012, the Nurse Practitioner documented "...f/u (follow-up)</p>	N 779	<p>Social Services has contacted the patient's family and followed up with the interdisciplinary team.</p> <p>After completion of skin assessments per nursing staff, no other residents were identified. Director of Social Services met with all social workers to ensure that there were no outstanding customer concerns regarding bruising of unknown origin.</p> <p>Under the direction of the Director of Social Services, an in-service was held for all social workers on 2/9/12 regarding documentation of timely follow up of family concerns.</p> <p>Director of Social Services will ensure the center's compliance with documentation by conducting an audit of 5 charts per month X 3 months to ensure compliance.</p>	

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N 779	Continued From page 3 on sacral contusion. Has faded quite a bit and would expect it to resolve in next 2-3 days". Review of Social Services notes from January 1, 2012 to January 24, 2012, revealed no documentation of the appearance of the bruise or family notification. Continued review of the facility investigation revealed no documentation the incident was considered possible abuse. Further review revealed no summary of the investigation or findings to support/discount the possibility of abuse. Continued review revealed no documentation of initial actions or investigation by the nurse who was notified of the appearance of the bruise, including assessment of the bruise and resident assessment for other bruises. Further review revealed no documentation of family involvement or Social Services involvement in the investigation. During interview on January 25, 2012, at 5:00 p.m., in the Director of Nursing's (DON) office, the DON confirmed there was no documentation from Social Services related to the family calling the Social Worker on January 18, 2012 and wanting to talk to someone related to the resident's bruising.	N 779	These audit findings will be reported to the quality assurance committee consisting of the Medical Director, Director of Nursing, Administrator and at least two other members of the health care center staff as requested by the quality assurance committee. The quality assurance studies and in-service training will be continued as determined by the Director of Nursing and/or as directed by the quality assurance committee.	2/9/12