STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER
445495

(X2) MULTIPLE CONSTRUCTION:
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
06/03/2011

NAME OF PROVIDER OR SUPPLIER
DOVE HEALTH & REHAB OF COLLIERVILLE, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
490 WEST POPLAR AVENUE
COLLIERVILLE, TN 38017

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

F 157 483.10(b)(11) NOTIFY OF CHANGES
(INJURY/DECLINE/ROOM, ETC)

ID PREFIX TAG
F 157

ID PREFIX TAG
F 157

F 157

1. The facility will ensure that the
physician and the family of the
residents who lose a significant amount
of weight will be notified.

Resident #6 has been discharged from
the facility.

2. Residents residing in the facility
have the potential to be affected.
Current residents will be assessed for
significant weight loss by the PAR
(Patients At Risk) committee by
6/25/11. The PAR Committee consists
of the DON, Dietary Manager, MDS
Coordinator, SSD, Activities Director,
and RN Supervisor. The physician and
family of residents with significant
weight loss that has occurred within the
past six months will be notified by the
DON or designee. The PAR committee
will continue to monitor residents with
significant weight loss weekly until
stable.

3. The DON or Designee will review
residents with significant weight loss
weekly x 4 weeks, then monthly, x 3
months to ensure that the physician and
family of residents with significant
weight loss have been notified.

This REQUIREMENT is not met as evidenced by:
Complaint #TN00027029

LABORATORY DIRECTOR OF PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DATE
06/29/2011

DEFICIENCY STATEMENT ENDING WITH AN ASTERISK (*) DENOTES A DEFICIENCY WHICH THE INSTITUTION MAY BE EXCUSED FROM CORRECTING PROVIDING IT IS DETERMINED THAT USE OF 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 PLAN 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 REQUIRED TO CONTINUE PROGRAM PARTICIPATION.
F 157 Continued From page 1

Based on medical record review and interview, it was determined the facility failed to consult and notify the physician and an interested family member of a significant weight loss for 1 of 9 (Resident #6) sampled residents.

The findings included:

Medical record review for Resident #6 documented an admission date of 9/22/10 with diagnoses of Hypertension, Dementia, Diabetes Mellitus, Cerebrovascular Accident and Hemiplegia. Review of the "Resident Weight Change History" for Resident #6 documented an admission weight on 9/22/10 of 189.6 pounds. Resident #6's weight on 10/26/10 was documented as 159.6 pounds indicating a significant weight loss of 5 percent (%) in a month. The facility was unable to provide documentation that the facility consulted the physician and notified an interested family member of the significant weight loss.

During an interview conducted via phone on 5/19/11 at 11:30 AM, the Directory of Nursing confirmed the facility was unable to locate the requested medical records.

F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

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.

F 157

4. The results of the reviews will be presented monthly to the QA Committee. The QA Committee is composed of the Medical Director, NHA, DON, Dietary Supervisor, and various employees from departments within the facility. The DON will present the findings to the QA Committee for further recommendations and or interventions.

1. The facility will continue to ensure physician orders for insulin administration are being accurately followed.

Resident #6 has been discharged from the facility.

2. Residents receiving insulin have a potential to be affected. Current MARs will be audited for administration of insulin according to physician orders by 6/25/11. Nurses were in service regarding blood
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 309</td>
<td>Continued From page 2</td>
<td>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to follow physician's orders for insulin administration for 1 of 9 (Resident #6) sampled residents. The findings included: Medical record review for Resident #6 documented an admission date of 9/22/10 with diagnoses of Hypertension, Dementia, Diabetes Mellitus, Cerebrovascular Accident and Hemiplegia. Review of the physician's orders for October 2010 documented orders for &quot;ACCUCHECK EVERY SIX HOURS W [with] /SSI [sliding scale insulin] NOVOLIN R [Regular] SC [subcutaneous] ...GREATER THAN 401= [amount of insulin to be administered] 12 UNITS SC AND RECHECK IN 2 HOURS IF STILL GREATER THAN 401, NOTIFY MD [Medical Doctor] /NP [Nurse Practitioner].&quot; Review of the physician's visit note dated 10/29/10 documented, &quot;Accu check ordered, 44.1.&quot; The facility was unable to provide documentation that 12 units of Novolin R insulin was administered as ordered. During an interview conducted via phone on 5/19/11 at 11:30 AM, the Director of Nursing confirmed the facility was unable to locate the requested medical records.</td>
<td>F 309</td>
<td></td>
<td>glucose monitoring, insulin administration, and documentation onto the MAR on 6/13/11. 3. The DON or Designee will conduct weekly MAR audits to ensure compliance with physician's orders and documentation x 4 weeks, then monthly x 3 months. 4. The results of the reviews will be presented monthly to the QA Committee. The QA Committee is composed of the Medical Director, NHA, DON, Dietary Supervisor, and various employees from departments within the facility. The DON will present the findings to the QA Committee for further recommendations and or interventions.</td>
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<tr>
<td>F 514</td>
<td>SS=D</td>
<td>483.75(1)(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, accurate, readily accessible and systematically organized.</td>
<td>F 514</td>
<td></td>
<td>1. The facility will maintain a separate medical record on each resident in accordance with accepted professional standards and practices that are complete, accurate, readily accessible and systematically organized.</td>
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**Notes:**
- **F 309**
- **F 514**
Continued From page 3

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 and interview, it was determined the facility failed to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete and accurately documented to show that the facility knows the status of each resident with changes in condition for 1 of 9 (Resident #6) sampled residents.

The findings included:

Medical record review for Resident #6 documented an admission date of 9/22/10 with diagnoses of Hypertension, Dementia, Diabetes Mellitus, Cerebrovascular Accident and Hemiplegia. Review of the “Resident Weight Change History” for Resident #6 documented an admission weight on 9/22/10 of 169.6 pounds. Resident #6’s weight on 10/26/10 was documented as 159.6 pounds indicating a significant weight loss of 5 percent (%) in a month. The facility was unable to provide documentation that the facility consulted the physician and notified an interested family.

F 514

2. Residents residing at the facility have the potential to be affected. Clinical records sign out sheets were placed at each nursing station on 6/13/11. The staff was in serviced on the record sign out form on 6/13/11. The Health Information Manager (HIM) will remove the permanently discharged resident’s medical record from the nurse’s station. The HIM will secure the record in the medical records office. The discharge chart sign out/in sheet will be utilized by disciplines removing the discharged resident’s chart from the medical records office.

The staff was in serviced on 6/13/11.

3. The DON or Designee will conduct audits to ensure that discharged resident’s medical records are removed from the nurse’s stations by the HIM. The audits will be conducted weekly x 4 weeks, then monthly x 3 months. The HIM will conduct audits to ensure the staff are utilizing the clinical record sign out sheets and the discharged sign out/in sheets. The audits will be performed weekly x 4 weeks, then monthly x 3 months.
NAME OF PROVIDER OR SUPPLIER
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F 514 Continued From page 4

member of the significant weight loss.


Review of the physician's visit note dated 10/29/10 documented, "Accu check ordered, 441." The facility was unable to provide documentation that 12 units of Novolin R insulin was administered as ordered.

During an interview conducted via phone on 5/19/11 at 11:30 AM, the Director of Nursing confirmed the facility was unable to locate the requested medical records.

(F514) ID
PREFIX
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PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

4. The results of the reviews will be presented monthly to the QA Committee. The QA Committee is composed of the Medical Director, NHA, DON, Dietary Supervisor, and various employees from departments within the facility. The DON and HIM will present the findings to the QA Committee for further recommendations and/or interventions.