

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 03/28/2024
NAME OF PROVIDER OR SUPPLIER Ave Maria Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2805 Charles Bryan Rd Bartlett, TN 38134	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33379</p> <p>Based on policy review, wunderground.com, medical record review, observation and interview, the facility failed to provide adequate supervision and an environment free of accident hazards for cognitively impaired residents and residents at risk of elopement for 2 of 5 (Resident #1 and #5) sampled residents reviewed for elopement and accident hazards. On 6/7/2023, Resident #1, a severely cognitively impaired resident, left the facility around lunch time without staff knowledge in her wheelchair, went down the facility drive, down a hill toward the facility dumpster, and was out of the facility at least 15 minutes. A facility staff member found Resident #1 when the staff member was going towards the dumpster, 360 feet from the facility. Resident #5 was a moderately cognitively impaired resident, assessed to be at risk for elopement and wandering, and the wandering placed him at significant risk of a dangerous place. On 1/9/2024 at approximately 5:45 PM, Resident #5 left the facility in their wheelchair through the side door without staff knowledge and was out of the facility at least 15 minutes. Resident #5 was found by a visitor, 274 feet from the facility, on a sidewalk by a parking lot, and the temperature was approximately 37 degrees. The facility failed to ensure interventions for Resident #5 were implemented timely, and failed to ensure the interventions were monitored for effectiveness. The facility's failure to implement interventions for a resident identified at risk of wandering and failure to ensure adequate supervision and an environment free of accidents and hazards resulted in Immediate Jeopardy for Resident #1 and Resident #5.</p> <p>Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident).</p> <p>The Administrator, the Director of Nursing (DON) and Administrator in Training (AIT) were notified of the IJ for F-689 on 3/25/2024 at 5:02 PM, in the Conference Room.</p> <p>A partial extended survey was conducted 3/26/2024 through 3/27/2024 for F689.</p> <p>The facility was cited Immediate Jeopardy at F-689, at a severity of J which is Substandard Quality of Care.</p> <p>The Immediate Jeopardy for F-689 began on 6/7/2023 and is ongoing.</p> <p>The findings include:</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. Review of the policy titled, Accidents and Supervision, dated 8/2023, revealed .The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents .Risk' refers to any external factor, facility characteristic .or characteristic of an individual resident that influences the likelihood of and an accident .'Supervision .' refers to intervention and means of mitigating risk of an accident .</p> <p>Review of the facility policy titled, Elopement and Wandering Elders, date reviewed 1/12/2024, revealed .This facility ensures that elders who exhibit wandering behavior and/or at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk .Wandering is random or repetitive locomotion .the person appears to be searching for something such as an exit .Elopement occurs when a resident leaves the premises or a safe area without authorization .The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering .</p> <p>2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses of Dementia, Hypothyroidism, Hypertension, and Muscle Weakness.</p> <p>Review of the Psychiatric Follow Up Note dated 3/15/2023, revealed .Medication maintenance follow up . Patient pleasantly confused upon approach .sitting in milieu [a person's social environment] .Patient [Resident #1] with Dementia .Will continue to monitor closely .</p> <p>Review of the Wander Data Collection Tool for Resident #1 dated 3/27/2023, revealed .Is the resident cognitively impaired with poor decision making skills .YES .Does the resident ambulate independently .YES . Does the resident have any visual, auditory or communication deficits .YES .Based off of the Summary of Findings, is resident a wander/elopement risk .No .</p> <p>Review of the Care Plan for resident #1 dated 3/29/2023, revealed .At risk for falls R/T [related to] impaired cognition, impaired safety awareness and hx [history] of falls .</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 4, which indicated Resident #1 was severely cognitively impaired, was not coded for wandering, and required extensive assistance with 1 person assist for transfers.</p> <p>Review of the Physician PROGRESS NOTE . dated 5/3/2023, revealed Resident #1 was .seen for evaluation, management and treatment of multiple complex medical diseases .Patient continued physical therapy treatment for functional decline .Mental status is confused. Patient does not walk but is up in a wheelchair .</p> <p>Review of the Resident Incident Report dated 6/7/2023, for Resident #1 revealed .Elder [Resident #1] noted outside of greenhouse home [a self-functional residential home] on front driveway. Elder brought back into home by DON and maintenance staff .</p> <p>Review of the wunderground.com [weather website] dated 6/7/2023, revealed the weather at 12:54 PM was 88 degrees.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the Wander Data Collection Tool for Resident #1 dated 6/7/2023, revealed .Has the resident wandered .YES .Does the wandering place the resident at significant risk of getting to a potentially dangerous place such .outside the facility .YES .Is the resident cognitively impaired with poor decision making skills .YES .Does the resident ambulate independently .YES .Does the resident verbally express the desire to go home or packed belongings to leave .YES .Does the resident have any visual, auditory or communication deficits .YES .Based off of the Summary of Findings, is resident a wander/elopement risk . YES .</p> <p>Observation in the living room area on 3/12/2024 at 4:45 PM, revealed Resident #1 neatly dressed and groomed, wearing glasses, sitting in a wheelchair in the living room area, talking to other residents, and pleasantly confused.</p> <p>During an interview on 3/13/2024 at 4:51 PM, Maintenance Staff M stated, .I think I was going to the dumpster .and I see a lady [Referring to Resident #1] .and I made a phone call .somebody got loose [to come assist] .she [Resident #1] was in a wheelchair .I went down and got her [Resident #1] .</p> <p>During an interview on 3/19/2024 at 11:04 AM, Staff A stated, .we just got through serving lunch .when I looked saw her [Resident #1] going in there [in the therapy room] .I knew she [Resident #1] would be in there for a while .I get a knock on the door from the DON and she said when was the last time [Staff A] seen [Named Resident #1] and said she [Resident #1] had got out .she [Resident #1] is very smart .she [Resident #1] watched us go into our rooms .she [Resident #1] looked around and .went out the front door .said they found her [Resident #1] down the hill .by the generator .gone about 10 minutes .one of the Maintenance man [men] brought her [Resident #1] back .</p> <p>During an interview on 3/19/2024 at 11:42 AM, Staff B stated, .sometimes that door [the door Resident #1 exited] doesn't close all the way .I was in the room [in another resident's room] and then they brought her [Resident #1] back in [in [NAME] House #1] .the DON came in and told me about it .they said she [Resident #1] had went down the hill by the dumpster .they fixed the door [door that Resident #1 eloped from] .</p> <p>During an interview on 3/19/2024 at 12:12 PM, the Director of Information Technology (IT) stated, .people think the mag [magnetic door locking system] was not shutting all the way and she [Resident #1] was able to press the button and get out .I checked the mag to make sure the mag was locking and replaced .exit button [green button] .</p> <p>During an interview on 3/20/2024 at 12:23 PM, the DON was asked how Resident #1 got out of the Greenhouse. The DON stated, .I was made aware by the Housekeeping Supervisor .she said elder [Resident #1] was out in her wheelchair .I retrieved her [Resident #1] from the parking lot from [Named Maintenance Staff M] .she [Resident #1] got out of the front door . The DON was asked if she aware of any problems of the door not closing all the way. The DON stated, No .he [IT- Information technologist] immediately worked on the door . The DON was asked did you ever monitor the door. The DON stated, No.</p> <p>The facility was unable to provide documentation the door was monitored to ensure the door continued to work correctly.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Observation outside of Greenhouse #1 on 3/20/2024 beginning at 3:00 PM, with Maintenance Staff #M, the Administrator, the DON, and the AIT revealed Maintenance Staff M used a measuring wheel to measure the distance where Resident #1 traveled [on 6/7/2023], from Resident #1's Greenhouse front door, on the sidewalk to the facility driveway, down the hill and left into a paved driveway. The measurement from the front door to where Resident #1 was located on 6/7/2023, measured approximately 360 feet.</p> <p>During an interview on 3/20/2024 at 3:20 PM, the Administrator was asked if a Greenhouse door is not working properly who should be notified. The Administrator stated, .Maintenance .they are on call 24/7 .</p> <p>During an interview on 3/25/2024 at 9:53 AM, the Maintenance Supervisor stated, .[Maintenance] sometimes get complaints that the door [door that Resident #1 eloped from] wasn't closing properly .we tell them [staff] you have to make sure they [staff] close the door properly .</p> <p>During a telephone interview on 3/25/2024 at 2:21 PM, the Maintenance Supervisor confirmed he didn't have a work order for the Greenhouse exit door that Resident #1 eloped from and stated, .if we had anything .it got thrown [thrown] away .</p> <p>3. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE], with diagnoses of Osteoporosis, Alzheimer's, Hypothyroidism, Dizziness and Giddiness, Abnormalities of Gait and Mobility, 4th and 7th Rib Fractures, and Cognitive Communication Deficit.</p> <p>Review of the Wander Data Collection Tool for Resident #5 dated 12/19/2023 revealed, .Has the resident wandered .Did the resident wander at home, in previous living settings, family/significant others voiced concerns .YES .Does the wandering place the resident at significant risk of getting to a potentially dangerous place such as stairs or outside the facility .YES .Is the resident cognitively impaired with poor decision making skills .YES .Dose the resident ambulate independently, with or without the use of assistive devices, including a wheelchair .YES .Does the resident have any visual, auditory or communication deficits .YES .Is the resident seeking to find spouse or family .YES .Based off the Summary of Findings, is resident a wander/elopement risk .YES, the resident is a wandering/elopement risk . The facility failed to implement interventions to address the elopement risk and wandering identified in the 12/19/2023 wander data collection tool.</p> <p>Review of the Physician Orders for Resident #5 revealed, .Order Date .12/19/23 .Monitor for behaviors q [every] shift .</p> <p>Review of the Care Plan for Resident #5 revealed, .12/22/2023 .Potential for decline in functional ability related to impaired mobility .Up in w/c [wheelchair] daily .Transfer with up to two person assist . The facility failed to implement interventions to address the elopement risk and wandering identified in the 12/19/2023 wander data collection tool.</p> <p>Review of the 5 day MDS dated [DATE], revealed Resident #5 had a BIMS score of 8 which indicated he was moderately cognitively impaired and was not coded for behaviors or wandering identified in the 12/19/2023 wander data collection tool.</p> <p>Review of the wunderground.com dated 1/9/2024, revealed the weather at 5:54 PM as 37 degrees.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the REPORTABLE INCIDENT CHECKLIST revealed, .THE INCIDENT [Elopement of Resident #5] OCCURRED 1-9-2024 .</p> <p>Review of the POST-INCIDENT ACTIONS for resident #5 dated 1/10/2024 at 6:00 PM, revealed, .Incident Type: Wander onto grounds [on 1/9/2024] .Equipment: Wheelchair .Exiting facility .Approx [approximately] 6 p.m [6:00 PM] .Shabhaz [A term the facility uses for Certified Nursing Assistant] approached this writer [Staff E] with elder in wheelchair stating that elder [Resident #5] was noted outside in parking lot by a visitor and was brought back into facility by the visitor .Immediate Post-Incident Action: Wander Guard .</p> <p>Review of the Physician Orders for Resident #5 dated 1/11/2024 revealed, .Apply Wanderguard Check function daily; Check placement q [every] shift .</p> <p>Review of the Departmental Notes revealed on 2/8/2024, Resident #5 was discharged home with family.</p> <p>Observation outside of [NAME] House #8 on 3/20/2024 beginning at 3:00 PM, with Maintenance Staff M, the Administrator, the DON, and AIT revealed Maintenance Staff M used a measuring wheel to measure the distance from the door Resident #5 eloped from, to the sidewalk, and to the parking lot where Resident #5 was found by a visitor. The measurement from the front door to where Resident #5 was located in the parking lot was approximately 274 feet.</p> <p>During a telephone interview on 3/18/2024 at 3:45 PM, Visitor #1 stated, .he [Resident #5] was about to come off the sidewalk into the parking lot .it was getting cold .about 5:30-6:00 [PM] o'clock . he [Resident #5] was headed completely opposite of where he needed to go . Visitor #1 confirmed she took him back into the Greenhouse.</p> <p>During an interview on 3/19/2024 at 9:20 AM, the DON confirmed Resident #5 had eloped on 1/9/2024. The DON was asked what measures were put in for Resident #5's elopement. The DON stated, .wander guard . The DON confirmed the wanderguard order was written on 1/11/2024.</p> <p>During a telephone interview on 3/19/2024 at 3:28 PM, Staff C stated, .camera showed he [Resident #5] went through the .door [side door] .about 15 minutes the doorbell ring [rings] .it was [Named Visitor #1] . bringing him [Resident #5] back .rolled him up in wheelchair .he felt so cold .he was dressed .no jacket .I took him right to the nurse and told her what happened .he had dementia .I don't know how he knew how to do that .went through the double doors [that goes through a hallway that leads to the side door] and pushed the green button .and then he went around sidewalk .he was in the parking lot .he was so cold .</p> <p>During an interview on 3/20/2024 at 2:24 PM, the AIT was asked what door Resident #5 got out of. The AIT stated, .we don't know for sure .we didn't see him [Resident #5] .there is a wall behind the kitchen .and we don't see him come out .the camera picked him up through a window in the therapy gym inside that house . there is a little walk way and he [Resident #5] was on that sidewalk .it's not on camera when the visitor met up with him .you can see him roll himself [in his wheelchair] to the sidewalk towards the main building and then it goes out of view . The AIT confirmed she doesn't know how long he was gone, and they believe he went out the laundry door.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/25/2024 at 12:09 PM, House Manager L was shown Resident #5's Wander Data Collection Tool assessment that was done on 12/19/2023 and confirmed he was an elopement and wandering risk. House Manager #1 was shown Resident #5's care plan and was asked if he was care planned for wandering and elopement. The House Supervisor stated, .I don't see anything .till 1/9 . House Manager #1 confirmed the care plan should have included interventions for wandering/elopement. House Manager #1 was shown the physician orders to apply wanderguard for Resident #5 and was asked the date the order was written for a wander guard. House Manager #1 stated, .1/11 .</p> <p>During an interview on 3/28/2024 at 7:45 AM, the DON confirmed that the facility was unable to provide documentation that Resident #5's wander guard was placed on 1/9 and stated, .we put it on just don't have documentation .</p> <p>The DON was unable to confirm the wander guard was placed on Resident #5 until 1/11/2024, 2 days after he eloped from the facility.</p>		