

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

PRINTED: 11/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445321	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/06/2014
NAME OF PROVIDER OR SUPPLIER ARDMORE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 25385 MAIN STREET ARDMORE, TN 38449		
(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	
F 253	Continued From page 1 housekeeping services was asked if he was aware of the lingering odors. The Regional Director stated, "Yes."	F 253	3. The Administrator or designee will conduct two random audits weekly for three weeks and the Administrator or designee will make environmental rounds daily for six weeks until offensive odors are consistently no longer noted.		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, it was determined the facility failed to ensure 2 of 4 (Nurses #1 and 2) nurses administered medications with a medication error rate of less than 5 percent (%). Four medication errors were made out of 29 opportunities for error, which resulted in a medication error rate of 13.79%. The findings included: 1. Medical record review for Resident #42 documented an admission date of 4/4/14 with diagnoses of Cerebrovascular Accident, Morbid Obesity, Hypertension and Diabetes Mellitus Type 2. Review of a physician's order dated 10/3/14 documented, "...Amlodipine 10MG [milligrams]... Take 1 tablet by mouth daily... 9AM... Clopidogrel 75MG... Take 1 tablet by mouth daily... 9AM..." Observations in Resident #42's room on 11/4/14 at 8:55 AM, Nurse #1 failed to administer Amlodipine 10 mg and Clopidogrel 75 mg to Resident #42. Failure to administer these two medications resulted in medication errors #1 and	F332	4. The Administrator or designee will compile audit results and present to quality assurance committee monthly for three months. Subsequent plans of action will be developed as indicated by the committee. The Administrator is responsible for overall compliance. 1. Resident # 42 and Resident #2 suffered no adverse outcomes related to the medication error. Licensed nurse #1 and Licensed nurse #2 were educated on properly following physicians orders. 2. No other residents were identified during the medication pass observation. All residents are potentially affected by similar deficient practices. Licensed nurses were educated by the Staff Development Coordinator or designee for medication administration policies including medication pass competency test and administering medications online course, and administering medications according to the physicians order and the facility policy on medication errors.	11/24/2014	11/5/14 11/21/14

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F 332	<p>Continued From page 2</p> <p>2.</p> <p>During an interview on the east hall on 11/5/14 at 9:10 AM, Nurse #3 and #4 verified Amlodipine 10 mg and Clopidogrel 75 mg had not been administered to Resident #42 on 11/4/14 as ordered.</p> <p>2. Medical record review for Resident #2 documented an admission date of 11/8/12 with a readmission date of 6/17/14 with diagnoses of Diabetes Mellitus. Review of a physician's order dated 10/3/14 documented, "...Humulin R [Regular insulin]... Accucheck twice daily with sliding scale... 251- [to] 300= [amount of insulin to be administered] 4 units... 6AM...8PM..."</p> <p>Observations in Resident #2's room on 11/4/14 at 11:24 AM, Nurse #2 performed an accucheck (fingerstick blood glucose test) on Resident #2 with results of 300. Nurse #2 administer Humulin R 4 units to Resident #2. The administration of the Humulin R resulted in medication error #3.</p> <p>Observations in Resident #2's room on 11/4/14 at 4:26 PM, Nurse #2 performed an accucheck on Resident #2 with results of 300. Nurse #2 proceeded to administered Humulin R 4 units to Resident #2. The administration of the Humulin R insulin resulted in medication error #4.</p> <p>During an interview on the west hall on 11/4/14 at 4:29 PM, Nurse #2 confirmed there was not a physician order for an accucheck or sliding scale insulin at 11:00 AM and 4:00 PM.</p> <p>During an interview in the nursing administration office on 11/5/14 at 9:30 AM, the Director of Nursing confirmed Nurse #2 did not have a</p>	F 332	<p>3. Nursing administration will conduct 2 random medication administration passes weekly for 3 weeks and then the Director of Nursing or designee will audit 1 medication administration pass per week for 6 weeks. Medication administration in-services will continue at least quarterly for licensed nurses.</p> <p>4. The Director of Nursing or designee will compile audit results and present to the Quality Assurance Committee meeting quarterly for 3 months. Subsequent plans of action will be developed as indicated by the committee. The Director of Nursing is responsible for overall compliance.</p>		

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F 333	Continued From page 4 Resident #2 with results of 300. Nurse #2 proceeded to administered Humulin R 4 units to Resident #2. The administration of the Humulin R insulin resulted in medication error #4. During an interview on the west hall on 11/4/14 at 4:29 PM, Nurse #2 confirmed there was not a physician order for an accucheck or sliding scale insulin at 11:00 AM and 4:00 PM. During an interview in the nursing administration office on 11/5/14 at 9:30 AM, the Director of Nursing confirmed Nurse #2 did not have a physician's order to perform an accucheck or administer sliding scale insulin at 11:00 AM and 4:00 PM.	F 333	4. The Director of Nursing or designee will compile audit results and present to the Quality Assurance Committee meeting quarterly for 3 months. Subsequent plans of action will be developed as indicated by the committee. The Director of Nursing is responsible for overall compliance.		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain a sanitary and environment free of offensive odors as evidenced by lingering offensive odors on 1 of 3 (North hall) halls. The findings included: Observations on the north hall revealed the presences of strong offensive odors on the following dates and times:	F 465	Resident rooms 34, 40, and 42 were all deep cleaned by 11/11/2014. Room 34 was stripped and waxed on 11/12/2014. Nursing staff was educated on perineal care. Resident in room 42 was assessed for self administration of medication and Chlorophyll tablets were offered to aid in reducing odor during colostomy care. Resident in Room 40 received sharps wound debridement on 11/6/14 by M.D. Resident in room 34 was placed on a toileting program and absorbent incontinent products were offered. North hall was deep cleaned and the air handler for North hall was serviced to ensure proper function.		

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F 465	<p>Continued From page 5</p> <p>a. 11/3/14 at 11:13 AM.</p> <p>b. 11/4/14 at 7:37 AM, 10:44 AM, 1:00 PM, 2:25 PM and 3:37 PM.</p> <p>c. 11/5/14 at 7:15 AM and 10:45 AM.</p> <p>During an interview on the north hall on 11/5/14 at 7:18 AM, the administrator confirmed the presence of lingering odors and stated "We have had problems with [odors in] certain rooms."</p> <p>During an interview on the north hall on 11/5/14 at 7:20 AM, the Regional Director of contracted housekeeping services was asked if he was aware of the lingering odors. The Regional Director stated, "Yes."</p>	F 465	<p>2. Walking rounds were performed by the Administrator and the Director of Nurses to identify any other areas with offensive odors. Nursing staff was in serviced on perineal care. Resident in room 42 was provided with chlorophyll to reduce odor during colostomy care. Resident in room 34 was offered incontinent supplies and placed on a toileting plan. Resident in room 40 received sharps debridement to wound by M.D. The air handler for North Hall was serviced to ensure proper function.</p> <p>3. The Administrator or designee will conduct two random audits weekly for three weeks and the Administrator or designee will make environmental rounds daily for six weeks until offensive odors are consistently no longer noted.</p> <p>4. The Administrator or designee will compile audit results and present to quality assurance committee monthly for three months. Subsequent plans of action will be developed as indicated by the committee. The Administrator is responsible for overall compliance.</p>	11/24/2014	

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