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

PRINTED: 08/11/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445321	A. BUILDING _____ B. WING _____	08/10/2011

NAME OF PROVIDER OR SUPPLIER: ARDMORE ON MAIN CARE 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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on policy review, observation, and interview, it was determined 1 of 6 (Nurse #1) medication nurses failed to maintain the privacy and confidentiality of a resident's Medication Administration Record (MAR). acceptable POC 8/24/11 SP [illegible]	F 164	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Ardmore on Main Care & Rehabilitation Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amy McCowan, NHA, Administrator

TITLE

(X6) DATE: 8/24/11

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.

This same report was faxed 8/24/11 SP

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F 164	Continued From page 1 The findings included: Review of the facility's "Safeguarding and Storage of Protected Health Information" policy documented, "...that reasonable administrative, technical and physical safeguards are in place to protect the privacy of protected health information...1. Department Heads/Center Staff ensures that protected health information (PHI) is securely stored and protected from damage, loss, destruction or unauthorized use..." Observation in the hall outside resident room 38 on 8/9/11 at 5:55 AM revealed Nurse #1 left a resident's MAR open and unattended on the medication cart while she entered resident room 38. Observation in the hall outside resident room 38 on 8/9/11 at 6:03 AM revealed Nurse #1 left a resident's MAR open and unattended on the medication cart while she entered resident room 36 to wash her hands. Observation in the hall outside resident room 38 on 8/9/11 at 6:10 AM revealed Nurse #1 left a resident's MAR open and unattended on the medication cart. During an interview in the hall outside room 38 on 8/9/11 at 6:25 AM, Nurse #1 was asked what is your policy for leaving the cart when administering medications and Nurse #1 stated, "...close the book." When asked if that is what she did, Nurse #1 stated "no." During an interview in the Social Services office	F 164	F164- 483.10(a), 483.75(i)(4) Personal Privacy/Confidentiality of Records. 1) The medication administration record was closed to maintain privacy. Licensed nurse #1 was provided re-education on maintaining privacy of the medical record on 8/10/11 by the Regional Director of Clinical Operations. 2) All medication administration records in the center contain protected health information and were reviewed to determine privacy and confidentiality was maintained on 8/10/11 by the Director of Nurses. 3) Licensed nurses were re-educated regarding the process of appropriate medication administration, including maintaining privacy of the medical record. This education was completed by administrative nursing staff by 8/16/11. 4) The Director of Nursing or designee will perform medication pass audits to include the task of maintaining privacy of the medical record (closing the MAR when not in use.) These audits will be performed three times per week for one month, then two times per week for two months. The Performance Improvement Committee consisting of the Medical Director, Administrator, Director of Nursing Services, Staff Development Coordinator, Activities Director, Social Services director, Maintenance director, and Nutritional Services director will monitor the results of the audits monthly for three months; subsequent plans of correction will be implemented as necessary based on the audit results.	08/24/11

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F 164	Continued From page 2 on 8/9/11 at 3:30 PM, the Director of Nursing (DON) was asked what should the nurse do with the MAR when leaving the cart. The DON stated, "close the MAR so the record is not visible."	F 164		
F 323 SS=D	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.	F 323		
	This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined the facility failed to follow interventions that were in place to prevent further falls for 1 of 6 (Resident #6) sampled residents with a history of falls and failed to develop new interventions after a fall for 1 of 6 (Resident #7) sampled residents. The findings included: 1. Medical record review for Resident #6 documented an admission date of 8/6/82 with diagnoses of Lack of Coordination, Abnormal Posture, Cognitive Deficits, Cerebral Vascular Disease, Seizures, Congestive Heart Failure, and Mental Retardation. Review of a fall investigation dated 1/29/11 documented, the resident fell during a transfer using the Hoyer lift by 2 staff members when transferring from the bed to the geriatric chair.			

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F 323	Continued From page 3 The fall investigation for 1/29/11 documented, there were no injuries and, "... interventions initiated immediately after fall: PT [Physical Therapy] and OC [Occupational Therapy] to evaluate for postural problems assist times 3 with all transfers..." Review of the fall investigation dated 4/4/11 documented Resident #6 experienced another fall related to use of the Hoyer lift due to improper placement of lift pad and only 2 staff members present for transfer. During an interview at the nurses' station on 8/10/11 at 11:30 AM, Nurse #4 stated, "...interventions placed on care plan on 2/18/11 that 3 people were to be present during use of the lift. A fall occurred on 4/4/11 when only 2 CNAs (Certified Nursing Assistants) were lifting the resident with the Hoyer lift. 2. Medical record review for Resident #7 documented an admission date of 1/28/11 with diagnoses of Epilepsy, Hypertension, Esophageal Reflux, Schizophrenia, Diabetes Mellitus, Anxiety, History of Fracture of Leg, and Dementia. Review of a "Risk Management System" form dated 3/30/11 documented, "...The nurse heard alarm sounding, upon entering residents room found tech [technician] assisting resident to sitting position on the floor...no injury..." Review of a "Risk Management System" form dated 4/9/11 documented, "...WENT TO 10A [room] PT [patient] ON HANDS AND KNEES IN FRONT OF BATHROOM...no injury..." Resident #7's care plan revealed no documentation of new interventions put in place for the fall on 3/30/11 or 4/9/11.	F 323	F323- 483.25(h) Free of Accident Hazards/Supervision/Devices 1) The fall care plan was reviewed and verified that interventions are currently being followed for resident #6. The fall care plan was reviewed to verify that current interventions are in place for resident #7 by the Assistant Director of Nurses (ADNS) on 8/11/11. 2) Residents who sustained a fall in the last 30days were identified and care plans were reviewed to determine that current interventions were in place and are being followed by 8/19/11 by the Director of Nurses (DNS), and ADNS. 3) Licensed nurses and Certified Nursing Assistants were re-educated on following the interventions for a fall on each resident's individualized plan of care. Licensed nurses were further re-educated on developing new interventions after a fall. This education was completed by administrative nursing staff by 8/16/11. 4) The Director of Nursing or designee will perform audits of fall care plans to determine that new interventions are developed and followed. These audits will include 10% of the residents and be performed weekly for one month and two times per month for two months. Audit results will be documented and taken to the Performance Improvement Committee Meeting. The Performance Improvement Committee consisting of the Medical Director, Administrator, Director of Nursing Services, Staff Development Coordinator, Activities Director, Social Services director, Maintenance director, and Nutritional Services director will monitor the results of the audits monthly for three months; subsequent plans of correction will be implemented as necessary based on the audit results.	08/24/11

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F 323	Continued From page 4 During an interview in room 25 on 8/10/11 at 8:45 AM, Nurse #5 stated, "...Re-educated, but that is not working. Guess we thought repeating would work. They [staff] probably couldn't think of anything new."	F 323		
F 332 SS=D	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 policy review, medical record review, observation and interview, it was determined the facility failed to ensure 2 of 6 (Nurse #1 and 2) nurses administered medications without a medication error rate of less that 5 percent (%) for sampled Resident #11 and Random Residents (RR) #1 and 2. A total of 11 medication errors were observed out of 40 opportunities for error, resulting in a medication error rate of 27.5%. The findings included: 1. Review of the facility's "General Dose Preparation and Medication Administration" policy documented, "...3.7 Facility staff should verify that the medication name and dose are correct...4. Prior to administration of medication, Facility staff should take all measures required by Facility policy and Applicable Law, including but not limited to the following: 4.1 Facility staff should: 4.1.1 Verify each time a medication is administered that it is the correct medication, at	F 332	F332- 483.25(m)(1) Free of Medication Error Rates of 5% or More. 1) Resident #11 was assessed for any signs or symptoms of hypo/hyperglycemia on 8/9/11 and none were identified by the licensed nurse. The physician was notified and no new orders were received on 8/9/11 by the licensed nurse. RR#1 was assessed by the licensed nurse for any adverse effects and none were identified on 8/9/11. The physician was notified and a clarification order for a multi-vitamin with minerals was obtained. RR#2 was assessed by the licensed nurse on 8/10/11 for any adverse effects and none were identified. The physician was notified and no new orders were received. Nurses #1 and #2 were provided re-education on proper medication administration on 8/10/11 by the DNS. 2) Residents receiving sliding scale Humulin R Insulin were identified and reviewed to verify insulin was being administered within 30-60 minutes of providing a meal or snack by the DNS on 8/10/11. Licensed nurse #1 & #2 were provided re-education regarding proper medication administration including prevention of medication errors on 8/10/11 by the DNS.	

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F 332	Continued From page 5 the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident..." 2. Medical record review for Resident #11 documented an admission date of 4/2/11 with diagnoses of Congestive Heart Failure, Hypertension, Bipolar Disorder, Diabetes Mellitus Type 2, and Chronic Airway Obstruction. Review of a physician's order dated 8/1/11 documented, "...HumuLIN R (Insulin Regular (Human)) 100 UNIT/ML [milliliters] Solution Subcutaneous (SQ) - Before Meals and at HS [bedtime] Everyday: FSBS [fingerstick blood sugar] AC [before meals] / HS WITH SLIDING SCALE COVERAGE 200-250 2 UNITS...MAKE SURE SNACK IS GIVEN WITHIN 30 MIN [minutes]. Observation in Resident #11's room on 8/9/11 at 6:10 AM revealed Nurse #1 administered 2 units of Humulin R Insulin to Resident #11. Nurse #1 did not offer the resident a snack. Resident #11 did not receive her breakfast meal until 7:35 AM, one hour and 25 minutes after administration of the Humulin R Insulin. Failure to provide a snack or meal within 30 minutes resulted in one medication error. During an interview in room 25 on 8/9/11 at 10:00 AM the Director of Nursing (DON) was asked what was the expectation when administering sliding scale insulin and the timing for receiving a meal. The DON stated, "Give a snack in 20 minutes if they haven't received the meal. Should get the meal within 30 minutes..." 3. Medical record review for RR #1 documented an admission date of 2/28/08 with a readmission	F 332	3) Licensed nurses were re-educated regarding the process of right time and right route proper medication administration, including the "five rights": right drug, right dose, right resident, as well as including administering Humulin R Insulin within 30-60 min. of a snack or meal. This education was completed by administrative nursing staff by 8/16/11. 4) The Director of Nursing or designee will perform medication pass audits to monitor for medication error rates greater than 5%. These audits will be performed randomly to include different nurses and medication administration times three times per week for one month, two times per week for two months. The Performance Improvement Committee consisting of the Medical Director, Administrator, Director of Nursing Services, Staff Development Coordinator, Activities Director, Social Services director, Maintenance director, and Nutritional Services director will monitor the results of the audits monthly for three months; subsequent plans of correction will be implemented as necessary based on the audit results.	08/24/11

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F 332	Continued From page 6 date of 6/6/08 with diagnoses of Diabetes Type 2, Peripheral Vascular Disease, Hypertension, Multinodular Goiter, and Dementia. Review of a physician's order dated 8/1/11 documented, "...Multivitamin/ [with] Minerals (Multivitamin) 1 tab [tablet] By mouth (Oral) - Daily Everyday..." Observation in RR #1's room on 8/9/11 at 8:37 AM revealed Nurse #2 administered a Multivitamin to RR #1. Failure to administer a Multivitamin with Minerals resulted in one medication error. During an interview at the nurses' station on 8/9/11 at 2:45 PM the DON was asked if the order was for Multivitamin with Minerals or Multivitamin. The DON stated, "...Should give Multivitamin with Minerals. I need to get that clarified." 4. Medical record review for RR #2 documented an admission date of 4/16/09 with a readmission date of 8/4/10 with diagnoses of Atrial Fibrillation, Chronic Kidney Disease, Esophageal Reflux, Senile Dementia, Depressive Disorder, Anemia, and Hypopotassemia. Review of a physician's order dated 8/1/11 documented, "Calcium...600 MG [milligram] By mouth - Daily Everyday...Digoxin 0.125 MG Tablet By mouth - Daily Everyday...Furosemide 20 MG Tablet By mouth - Daily Everyday...Lisinopril 10 MG Tablet By mouth - Daily Everyday...metoprolol tartrate 50 MG By mouth - Daily Everyday...Multivitamins 1 TAB [tablet] By mouth - Daily Everyday...Namenda...5 MG Tablet By mouth - Twice a Day...Potassium Chloride 10 MEQ [milliequivalent] Capsule...By mouth - Daily Everyday...Vitamin D...800 UNIT By mouth - Daily	F 332		

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F 332	Continued From page 7 Everyday..." Observations in RR #2's room on 8/9/11 at 8:45 AM revealed Nurse #2 crushed Calcium 600 mg, Digoxin 0.125 mg, Furosemide 20 mg, Lisinopril 10 mg, Metoprolol Tartrate 50 mg, Multivitamin 1 tablet, Vitamin D 800 units, and Namenda 5 mg. Nurse #2 opened the Potassium Chloride capsules and poured into the medication cup and mixed with the crushed medications in applesauce. Nurse #2 administered the medications in applesauce to RR #2 with a spoon, leaving some of the medication and applesauce in the medication cup and on the spoon and discarded in the trash can. Failure to administer all of the medications resulted in eleven medication errors. During an interview in the East hallway on 8/9/11 at 9:00 AM Nurse #2 was asked if she administered all of the medications ordered. Nurse #2 stated, "She will only take one spoonful and that is it. I can't get it [medications] all in one spoonful. Nurse #2 did not offer the remaining medication to RR #2. During an interview in room 25 on 8/9/11 at 10:00 AM the DON was shown the medication cup and spoon with the medications and applesauce. The DON stated, "There is still medication on the spoon and in the cup too."	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors.	F 333		

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F 333	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on review of the "MED-PASS COMMON INSULINS: provided by the American Society of Consultant Pharmacist", policy review, medical record review, observation and interview, it was determined the facility failed to ensure residents were free of significant medication error when 1 of 6 (Nurse #1) nurses failed to administer insulin within the proper time frame before receiving food. The findings included: 1. Review of the "MED-PASS COMMON INSULINS: Pharmacokinetics, Compatability, and Properties" provided by the American Society of Consultant Pharmacist for typical dosing administration of insulin related to meals documented, "Humulin R...ONSET (In hours, Unless Noted)...0.5 - 1 [hours]...TYPICAL DOSING/COMMENTS...30 minutes prior to meals..." 2. Review of the facility's "SPECIAL CONSIDERATIONS FOR ADMINISTRATION OF INSULIN" policy documented, "...determine the current blood glucose level and when the patient will eat. Knowing the peak action and duration of the insulin protocol is essential when developing an effective diabetes management plan..." 3. Medical record review for Resident #11 documented an admission date of 4/2/11 with diagnoses of Congestive Heart Failure, Hypertension, Bipolar Disorder, Diabetes Mellitus Type 2, and Chronic Airway Obstruction. Review of a physician's order dated 8/1/11 documented,	F 333	F333- 483.25(m)(2) Residents Free of Significant Med Errors. 1) Resident #11 was assessed for any signs or symptoms of hypo/hyperglycemia on 8/9/11 and none were identified by the licensed nurse. The physician was notified and no new orders were received on 8/9/11 by the licensed nurse. 2)) Residents receiving sliding scale Humulin R insulin were identified and reviewed to verify insulin was being administered within 30-60 minutes of providing a meal or snack by the DNS on 8/10/11 No other residents were affected. Licensed nurse #1 was provided re-education regarding proper medication administration including administering insulin within the proper time frame before receiving food on 8/10/11 by the DNS. 3) Licensed nurses were re-educated regarding the process of proper medication administration, including administering Humulin R insulin within 30-60 min. of a snack or meal. This education was different nurses and medication completed by administrative nursing staff by 8/16/11. 4) The Director of Nursing or designee will perform medication pass audits to determine sliding scale insulin is administered within the proper time frame before receiving food. These audits will be performed randomly to include per administration times three times week for one month, two times per week for two months.	

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F 333	Continued From page 9 "...HumuLIN R (Insulin Regular (Human)) 100 UNIT/ML [milliliters] Solution Subcutaneous (SQ) - Before Meals and at HS [bedtime] Everyday: FSBS [fingerstick blood] AC [before meals] / HS WITH SLIDING SCALE COVERAGE 200-250 Give 2 UNITS...MAKE SURE SNACK IS GIVEN WITHIN 30 MIN [minutes]." Observation in Resident #11's room on 8/9/11 at 6:10 AM revealed Nurse #1 administered 2 units of Humulin R Insulin to Resident #11. Nurse #1 did not offer the resident a snack. Resident #11 did not receive her breakfast meal until 7:35 AM, one hour and 25 minutes after the administration of the Humulin R Insulin. Failure to provide a snack or meal within 30 minutes resulted in one medication error. During an interview in room 25 on 8/9/11 at 10:00 AM the Director of Nursing (DON) was asked what was the expectation when administering sliding scale insulin and the timing for receiving a meal. The DON stated, "Give a snack in 20 minutes if they haven't received the meal. Should get the meal within 30 minutes..."	F 333	The Performance Improvement Committee consisting of the Medical Director, Administrator, Director of Nursing Services, Staff Development Coordinator, Activities Director, Social Services director, Maintenance director, and Nutritional Services director will monitor the results of the audits monthly for three months; subsequent plans of correction will be implemented as necessary based on the audit results.	08/24/11
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically	F 334		

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F 334	Continued From page 10 contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and	F 334	F334- 483.25(n) Influenza and Pneumococcal Immunizations. 1) The physician of resident #7 was notified that the influenza immunization was not administered during the flu season by the licensed nurse on 8/10/11. There were no new orders received. ***Documentation was obtained from the VA at Murfreesboro that resident #7 received a pneumonia vaccine on 2/14/10.*** 2) Current residents immunization records were reviewed to determine an influenza vaccine and pneumonia vaccine was provided as ordered by the DNS, ADNS and UM on 8/22/11. 3) Licensed nurses were re-educated regarding offering the influenza & pneumonia vaccine. This education was completed by administrative nursing staff by 8/16/11. 4) The Director of Nursing or designee will audit new admission charts to determine that any resident with both a consent and a physician order, is provided an influenza vaccine (during the flu season) and a pneumonia vaccine. The Performance Improvement Committee consisting of the Medical Director, Administrator, Director of Nursing Services, Staff Development Coordinator, Activities Director, Social Services director, Maintenance director, and Nutritional Services director will monitor the results of the audits this month and again in October and annually in October thereafter.	08/24/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445321		08/10/2011

NAME OF PROVIDER OR SUPPLIER: ARDMORE ON MAIN CARE AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 25385 MAIN STREET, ARDMORE, TN 38449

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F 334	Continued From page 11 (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on the facility's policy review, medical record review, and interview, it was determined the facility failed to provide the influenza and pneumococcal vaccine for 1 of 13 (Resident #7) sampled residents. The findings included: Review of the facility's "Resident Vaccine Administration Guidelines" policy documented, "...Residents are offered annual influenza (flu) vaccine during the flu season Oct. [October] 1-Mar. [March] 31...Resident/responsible party signs informed consent...permitting the administration of the vaccine...licensed nurse administers the vaccine as ordered...Resident is offered Pneumococcal vaccination..." Medical record review for Resident #7 documented an admission date of 1/28/11 with diagnoses of Epilepsy, Hypertension, Esophageal	F 334		

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 08/10/2011
NAME OF PROVIDER OR SUPPLIER: ARDMORE ON MAIN CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 25385 MAIN STREET, ARDMORE, TN 38449	

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F 334	Continued From page 12 Reflux, Schizophrenia, Diabetes Mellitus, Anxiety, History of Fracture of Leg, and Dementia. The facility was unable to provide documentation that the flu or pneumococcal vaccine had been administered to Resident #7. During an interview in room 25 on 8/9/11 at 10:00 AM the Director of Nursing stated, "I didn't see where he [Resident #7] got the flu or pneumonia vaccine and I didn't find a consent or refusal."	F 334		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431	F431- 483.60(b),(d),(e) Drug Records, Label/Store Drugs & Biologicals. 1) The medication cart was locked by the licensed nurse. Nurse #1 was provided re-education on locking of medication carts when unattended on 8/9/11 by the DNS. 2) Other Med carts were checked and medications found to be secured and carts locked on 8/9/11 by nursing administration. 3) Licensed nurses were re-educated regarding the process of locking the medication cart when unattended. This education was completed by administrative nursing staff by 8/16/11. 4) The Director of Nursing or designee will perform random audits to monitor that medication carts are locked when unattended. These audits will be performed randomly to include different nurses three times per week for one month, two times per week for two months.	

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F 431	Continued From page 13 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure a medication cart was locked and medications were not left unattended in 1 of 5 (West Wing medication cart) medication storage areas. The findings included: Review of the facility's "General Dose Preparation and Medication Administration" policy documented, "...7. Facility should ensure that medication carts are always locked when out of sight or unattended." Observations in the North Wing hallway on 8/9/11 at 5:55 AM and 6:10 AM revealed the North Wing medication cart was left unattended, unlocked and out of view of the nurse. During an interview in the North Wing hallway on 8/9/11 at 6:25 AM Nurse #1 was asked if the medication cart was locked when she left the hallway. Nurse #1 stated, "No, not if you are asking."	F 431	The Performance Improvement Committee consisting of the Medical Director, Administrator, Director of Nursing Services, Staff Development Coordinator, Activities Director, Social Services director, Maintenance director, and Nutritional Services director will monitor the results of the audits monthly for three months; subsequent plans of correction will be implemented as necessary based on the audit results.	08/24/11
F 502	483.75(j)(1) ADMINISTRATION	F 502		

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

PRINTED: 08/11/2011
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OMB NO. 0938-0391

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F 502 SS=D	Continued From page 14 The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to ensure lab results were obtained in a timely manner when ordered by the physician for 1 of 16 (Resident #4) sampled residents. The findings included: Medical record review for Resident #4 documented an admission date of 12/11/07 and a readmission date of 2/12/10 with diagnoses of Urinary Retention, Esophageal Reflux, Diabetes Mellitus, Diabetic Retinopathy, Stage 4 Renal Disease, Hypertension, Obesity, and Benign Prostatic Hypertrophy. Review of a physician's order dated 7/22/11 documented, "...Amoxicillin 500 mg [milligrams] q [every] 8 h [hours[X [times] 7 days then do U/A [urinalysis] [symbol for with] C [culture] [symbol for and] S [sensitivity] on day 10..." The facility was unable to provide documentation that the UA C&S had been obtained as ordered. During an interview in the Social Services' office on 8/9/11 at 3:25 PM the Director Of Nursing verified that the UA C&S had not been obtained as ordered by the physician.	F 502	F502- 483.75(j)(1) Administration 1) Resident #4 was assessed for any adverse signs or symptoms by the licensed nurse on 8/10/11 and none were identified. The physician was notified of the lab not being obtained and new orders were received to discontinue the lab order. The licensed nurse was provided re-education on following physician orders and obtaining labs as ordered by the DNS on 8/11/11. 2) Current resident medical records were reviewed for lab orders in the last 30 days to determine that labs were obtained as ordered by the DNS and ADNS on 8/18/11. 3) Licensed nurses were re-educated regarding the process of obtaining lab in a timely manner as ordered. This education was completed by administrative nursing staff by 8/16/11. 4) The DNS or designee will conduct lab audits 2x weekly for 1 month, then weekly for 2 additional months to determine that labs are obtained as ordered. The Performance Improvement Committee consisting of the Medical Director, Administrator, Director of Nursing Services, Staff Development Coordinator, Activities Director, Social Services director, Maintenance director, and Nutritional Services director will monitor the results of the audits monthly for three months; subsequent plans of correction will be implemented as necessary based on the audit results.	08/24/11