

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445321	JUN 18 2010 (X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED 05/19/2010
		A. BUILDING _____	B. WING _____	

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 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and interviews, it was determined the facility failed to ensure staff notified the attending physician of</p>	F 157	<p>"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 exists, 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."</p> <p><u>F157</u></p> <p>1. RI #1 was reassessed and re-evaluated for pain by the Licensed Nurse on May 26, 2010. MD was notified on May 26, 2010.</p> <p>RI #21 was reassessed by the Licensed Nurse on May 26, 2010. MD was notified of Blood Glucose parameters less than 60 and there were no new orders.</p> <p>Attending physicians were called by the licensed nurses on 5/19/2010 to discuss the sliding scales with the physicians. No changes were made to sliding scales.</p>	

Acceptable per 4/11/10 provider

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Diana Fisher</i>	TITLE <i>Administrator</i>	(X6) DATE <i>6/4/10</i>
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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 2567 was for the 6/4/10 survey

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F 157	<p>Continued From page 1</p> <p>head injuries/swollen and painful knee, and low blood sugars (BS) for 2 of 23 (Residents #1 and 21) sampled residents.</p> <p>The findings included:</p> <p>1. Review of the facility's "Falls Management" policy documented, "When a Resident Falls Notify the licensed nurse who will: ...5. Notify the physician and the resident's responsible party."</p> <p>Medical record review for Resident #1 documented an admission date of 10/6/06 with diagnoses of Depressive Disorder, Dementia with Behaviors, Anxiety State, Alzheimer's Dementia, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Atrial Fibrillation, Peripheral Vascular Disease and history of Carotid Artery Occlusion with Infarct. Review of Resident #1's nurses' notes dated 10/12/09 "7A 7P" documented, "CNA [Certified Nursing Assistant #6] Reported a bruise to Residents [#1's] ^ [upper] hairline. Appears Resident hit her head on the Siderail. Siderails were padded p [after] the fact to prevent future incidents. Also noticed (L) [left] knee was swollen. Resident appear to be in some pain when it [left knee] is touched. Will monitor if worsen will notify MD [Medical Doctor]. There was no further documentation regarding the injury until 10/13/09 at 1:05 PM.</p> <p>During an interview in the Director of Nursing's (DON) office on 5/18/10 at 9:30 AM, the DON stated, "The physician should have been notified on 10/12/09."</p> <p>2. Medical record review for Resident #21 documented an admission date of 7/30/08 with</p>	F 157	<p>2. A Pain Assessment Audit was conducted May 26-June 2, 2010 by the Assistant Director of Nursing and unit managers for residents receiving scheduled pain medication regimes and prn pain medication regimens and it was documented.</p> <p>An MD Notification audit was conducted by the Director of Nursing, Assistant Director, and Unit Manager on May 26-June 3, 2010 of residents with events over the past 30 days and the physicians were notified as needed.</p> <p>An audit of blood sugars was conducted by the Licensed Nurses on May 19, 2010 of residents receiving sliding scale insulin.</p> <p>3. On May 27, 2010, licensed staff were re-educated by the Director of Nursing on timely MD notification with event reporting and blood sugars that are <60.</p> <p>4. The Director of Nursing and Assistant Director of Nursing will conduct audits of blood sugars and event reporting to ensure MD notification. These audits will be conducted 3x weekly x 4 weeks; then weekly x 1 month for a period of three months.</p> <p>The Performance Improvement Committee consisting of the Medical</p>	

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F 157	Continued From page 2 diagnoses of Diabetes Mellitus, Congestive Heart Failure, Morbid Obesity and Hypertension. Review of a physician's order dated 1/4/10 and updated 4/29/10 documented, "...Accucheck before meals and at bedtime... Blood sugar [BS] parameters BS > [greater than] or equal to 350 call M.D. [Medical Doctor] & [and] follow orders. BS < [less than] or equal to 60 tx [treat] w [with]/ 10 - [to] 15 grams of fast acting carbs [carbohydrates] (4oz. [ounces] OJ [orange juice]/2 sugar pkts [packets]/individual jelly/or 1 mg [milligram] glucagon sub-q [subcutaneous] or im [intramuscular], call M.D...." Review of Resident #21's "Blood Glucose Tracking Form" documented the following BS results: a. January 26, 2010 at 6:00 AM, BS was (=) 55. b. March 25, 2010 at 4:30 PM, BS=56. c. April 10, 2010 at 11:00 AM, BS =59. There was no documentation in Resident #21's medical record the physician was notified of these BS's that were less than 60. During an interview in Room 44 on 5/19/10 at 6:00 PM, the DON stated, "It [referring to physician notification] should be on the sheet [referring to Blood Glucose Tracking Form] or in the nurse's notes. If it's not there, then the doctor wasn't notified."	F 157	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 MD notification audits monthly for three months; subsequent plans of correction will be implemented as necessary based on the audit results.	6/14/2010
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,	F 164	F164 I. A review of Medication Administration Records on the East and North Hall was conducted on May 19, 2010 by the Director of Nursing and was in Compliance.	

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F 164	<p>Continued From page 3</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, it was determined the facility failed to provide privacy of medical records on 2 of 3 halls (East hall and North hall) on 2 days (5/18/10 and 5/19/10) of the survey.</p> <p>The findings included:</p> <p>1. Observations on the East hall on 5/18/10 at 7:55 AM, revealed a Medication Administration Record (MAR) was lying open on the medication cart with resident information in public view to anyone who passed by. No nursing personnel were in attendance.</p>	F 164	<p>2. A review of the Medication Administration Records and areas of the facility containing protected health information was conducted on May 19, 2010 by the Director of Nursing and Assistant Director of Nursing to ensure the privacy of the medical record.</p> <p>3. Re-education was provided by the Staff Development Coordinator on May 26-27, 2010 on privacy of medical records.</p> <p>4. The Director of Nursing, Assistant Director of Nursing, and Unit Managers will check the Medication Administration Records 3x weekly x 1 month, then 2x weekly for 2 months. Audit results will be documented and taken to the Performance Improvement Committee Meeting.</p> <p>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 privacy audits monthly for three months; subsequent plans of correction will be implemented as necessary based on the audit results.</p>	6/14/2010
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F 164	Continued From page 4	F 164		
F 203 SS=D	<p>2. Observations on the North hall on 5/19/10 at 3:30 PM, revealed a MAR was partially open on the medication cart with resident information in public view to anyone who passed by. No nursing personnel were in attendance.</p> <p>483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE</p> <p>Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section.</p> <p>Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.</p> <p>The written notice specified in paragraph (a)(4) of this section must include the reason for transfer</p>	F 203	<p><u>F203</u></p> <ol style="list-style-type: none"> 1. Resident Identifier #19 discharged home on May 16, 2010. RR #4 cell phone was returned to the resident on May 16, 2010. 2. The Social Services Director conducted audits on May 26-June 3, 2010 of the last 5 residents discharged from the center. 3. On May 26, 2010, the Administrator re-educated the Social Services Director on notice requirements before and after discharge and on notifying the Ombudsman as warranted. <p>On May 27, 2010, the Social Services Director and Director of Nursing re-educated the licensed nursing staff on documentation guidelines for discharging residents home.</p> <ol style="list-style-type: none"> 4. The Social Services Director and Health Information Director will audit discharge resident's medical records 	

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F 203	<p>Continued From page 5</p> <p>or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>This REQUIREMENT is not met as evidenced by: Based on closed medical record review and interview, it was determined the facility failed to provide in writing the reason for discharge, the right of appeal, and how to contact the ombudsman for 1 of 6 (Resident #19) closed records reviewed.</p> <p>The findings included:</p> <p>Medical record review for Resident #19 documented an admission date of 4/13/10 with diagnoses of Muscle Weakness, Pressure Ulcer Buttocks Stage Four, Thrombocythemia, Anemia, Pyelonephritis, Colostomy and Lower Limb Amputation. Review of Resident #19's "Interdisciplinary Progress Note" for nursing documented the following:</p>	F 203	<p>weekly x 4 weeks for agency referrals, discharge planning documentation and then monthly for the next two months. The findings will be taken to Performance Improvement Committee.</p> <p>The Performance Improvement Committee consisting of the Medical Director, Administrator, Director of Nursing, Staff Development Coordinator, Activities Director, Social Services Director, Maintenance Director, and Nutritional Services Director will monitor the results of the discharge resident's audits in the monthly Performance Improvement Committee meeting; subsequent plans of correction will be implemented as necessary.</p>	6/14/2010

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F 203	Continued From page 6 a. 5/15/10 documented, "12 noon - Pt [patient #19] outside on front porch of facility listening to his CD [Compact Disc] player rap music. [Named Resident #21] was also outside. [Named Resident #19] had music playing and was going to go back into facility and he [Resident #21] asked [Named Resident #19] to turn music off if he was going in. He [Resident #21] said [Named Resident #19] became very upset stating he would do whatever the hell he wanted to do and then threw some popsicle holders at [Named Resident #21] and continued to cuss him so [Named Resident #21] became mad and took his ankle weight off his chair and threw it back at [Named Resident #19] hitting him [Resident #19] in the chest. [Named Resident #19] became very upset and came into building cussing at staff. He [Resident #19] was instructed to please be quiet and quit cussing so loud in front of family members and other residents. Resident [#19] did not care but did leave continuing to curse staff. He [Resident #19] came back to nursing station and called 911 and reported an assault against him. [Named police department] did come to facility and spoke c [with] both residents. Residents chose not to press charges against one another. [Named Administrator] notified of above. [Named Social Services Director] notified of above. Will continue to monitor... 5/15/10-930p ...A few verbal outburst early evening, quieter by 10p." b. "5/16/10-6a Argument continues c [with] resident in [gave room number of Resident #21]. Each accusing the other of assault. Suggested by charge nurse that both stay away from each other... 5/16/10-730am-Resident in shower c CNA [Certified Nursing Assistant] [named CNA #5]. While in shower room she [CNA #5] transferred	F 203		

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F 203	<p>Continued From page 7</p> <p>some of his clothes and while doing so a cell phone dropped onto floor. [Resident #19] did not notice it [cell phone] and [Named CNA #5] was able to get phone. [Named CNA #5] brought phone to nursing station and they discovered phone to be [Named Random Resident (RR) #4] [Named Resident #19's] previous roommate... 5/16/10-2p"-Pt [Resident #19] discharged home with mother. 0 [No] c/o [complaint of] pain."</p> <p>Review of the Social Services Director's (SSD) "Interdisciplinary Progress Notes" for Resident #19 documented the following:</p> <p>a. 5/7/10 "...No mood indicators noted during this review. Writer is assisting resident with application for public housing. Resident is short term placement. Resident has had some issues following policies & [and] rules of facility. 1:1 [one on one] provided as needed."</p> <p>b. 5/14/10 documented, "Note: Explained to resident that we would be allowing others to borrow cigarettes during smoke breaks anymore because it's causing a financial hardship on those giving cigarettes to others..."</p> <p>c. "5/17/10-5:30p ...Resident d/c [discharged] home on 5/16/10 with mother. Resident was apparently threatening other residents and taking items, snacks, etc. [etcetera] from other resident rooms..."</p> <p>Review of the "24 Hour Report of Resident Change In Condition Book" dated 5/16/10 documented, "...[Named Resident #19] [Named Assistant Director of Nursing (ADON)] called mother to come pick him [Resident #19] up d/t [due to] continuous inappropriate behaviors..."</p> <p>During an interview in Room 44 on 5/19/10 at 2:55 PM, the ADON stated, "Issues with him</p>	F 203		
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F 203	<p>Continued From page 8</p> <p>[referring to Resident #19] had caught him outside smoking, confiscated his lighter and cigarettes. Had talked with [RR #4] about his missing cell phone. [Named Resident #19] had been seen using the resident's [RR #4's] phone. He [Resident #19] saw us talking to the resident [RR #4] and left the phone on the table. He [Resident #19] pulled the fire alarm on Saturday, made comment he had stolen so many things on Saturday night didn't know what all he had taken..."</p> <p>During an interview in Room 44 on 5/19/10 beginning at 2:55 PM, when asked if Resident #19 had been discharged because he wanted to go home or if it was the facility's decision to discharge him. The ADON stated, "We discharged him. It was either send him home with his mother or send him to a homeless shelter. We dc'd [discharged] him to his mother when he kept getting worse. We couldn't handle him so we asked his mother to take him home, that was the best option. Chemical restraints were suggested but we weren't comfortable with that, so the best thing was to get him out of here [the facility]."</p> <p>During a telephone interview with the Ombudsman on 5/20/10 at 11:00 AM, the Ombudsman confirmed that she was not contacted by the facility about the discharge of Resident #19 prior to his discharge from the facility.</p> <p>There was no documentation in Resident #19's medical record that the facility had notified the resident's responsible party in writing of the reason for the discharge, how to appeal the discharge, and how to contact the ombudsman.</p>	F 203		
F 250	483.15(g)(1) PROVISION OF MEDICALLY	F 250		

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F 250 SS=E	<p>Continued From page 9 RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, review of the Social Service Director's job description, medical record review, and interviews, it was determined the facility failed to provide psychosocial interventions or documentation for 5 of 23 (Residents #2, 4, 5, 8 and 19) sampled residents with problem behaviors.</p> <p>The findings included:</p> <p>1. Review of the facility's "Social Services Assessment & [and] Documentation" policy and procedure documented, "Procedure... 5. The Social Services Director[SSD]/designee completes a review of residents at least quarterly, upon readmission, or significant change in condition; this review may reflect, but not limited to: Changes in psychosocial functioning since last review... Social functioning and adjustment to placement; Medical issues impacting the resident's psychosocial well being... Behavioral issues/concerns; Alternatives explored and agreements made with the resident or family member/responsible party regarding goals and care plan... Social service interventions, observations and recommendations; One to one social service visits/sessions with residents...7. The Social Services Director/designee is</p>	F 250	<p><u>F250</u></p> <p>1. RI #2 was re-assessed and care plan was updated by Social Services Director on May 26, 2010 to reflect the resident's psychosocial intervention.</p> <p>RI #4 was re-assessed and care plan was updated by the Social Services Director on May 27, 2010 to reflect the resident's psychosocial intervention.</p> <p>RI #5 was re-assessed and care plan was updated to reflect Hospice services by the Social Services Director on May 27, 2010.</p> <p>RI #8 was re-assessed and care plan was updated to reflect psychosocial issues by the Social Services Director on May 27, 2010.</p> <p>RI #19 was discharged from the center on May 16, 2010.</p> <p>2. An audit of the social services notes related to timeliness of assessments was completed by the Social Services Director on May 26-June 3, 2010. Assessments were completed as indicated.</p> <p>An audit of social work notes related to residents receiving Hospice was</p>	

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 05/19/2010
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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 250	<p>Continued From page 10</p> <p>responsible for coordinating, obtaining, charting and/or filing documentation including but not limited to: Individualized social service care plan, as applicable... Notice of Transfer or Discharge... Notice of Bed Hold Policy and Authorization..."</p> <p>Review of the facility's "POSITION DESCRIPTION... Director of Social Services" documented, "...1. Plan, develop, organize, implement, evaluate, and direct the social service department to meet medically related social and emotional needs of the residents...7. Assesses residents upon admission, quarterly, and change of condition for social service needs... 8. Performs documentation duties as required... Ensures documentation is accurate, informative, and descriptive of the resident's condition, nursing care provided and resident's response to the care..."</p> <p>2. Medical record review for Resident #2 documented an admission date of 10/30/09 with diagnoses of Anemia, Hypothyroidism, Pulmonary Embolism and Infarction, Psychosis and Depressive Disorder. Review of the Nurses Notes dated 2/4/10 8:30 AM documented, "Spoke c [with] Dr. [Named physician] regarding resident [#2] being tearful this a.m. making statements 'I wish I could be with my wife' (Wife is deceased.) New orders received..." Review of the Mental Health Progress Notes documented Resident #2 began receiving treatment on 2/10/10. Review of the Interdisciplinary Progress Notes revealed quarterly Social progress notes dated 1/18/10 and 4/12/10. The SSD quarterly progress note dated 4/12/10 documented, "No mood indicators noted during review..." There was no documentation found in the Social progress notes concerning Resident #2's statement of wishing he could be</p>	F 250	<p>completed by the Social Services Director on May 26-June 3, 2010. Social work notes and care plans were updated to reflect Hospice services.</p> <p>An audit of residents with psychosocial issues will be completed by the Social Services Director by June 4, 2010. Notes and care plans will be updated by June 13, 2010.</p> <p>3. Re-education was provided to the Social Worker by the Administrator on May 26, 2010 on addressing the resident's psychosocial needs and regarding timeliness and accuracy of documentation.</p> <p>4. The Social Services Director and Director of Nursing will conduct audits on 5 charts weekly x 4 weeks and 3 charts monthly x 2 month.</p> <p>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 social work audits monthly for three months; subsequent plans of correction will be implemented as necessary based on the audit results.</p>	6/14/2010

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

PRINTED: 05/24/2010
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 05/19/2010
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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 250	<p>Continued From page 11 with his wife who passed away in October 2009.</p> <p>3. Medical record review for Resident #4 documented an initial admission date of 1/22/10 with diagnoses of Hepatocellular Carcinoma, Depressive Disorder, Cerebrovascular Disease with Hemiplegia, Bipolar and a current admission date of 3/4/10. A care plan initiated 2/19/10 documented, "Focus - Potential for injury; smokes; non-compliant with smoking policies." Interventions for this care plan included, "...Educate Resident/family on time schedule for resident smoking. Education Resident/family on location approved for resident smoking. Explain the smoking policy and procedures implemented by the center as needed. Report any non compliance with smoking safety rules to physician and center administrator..." The care plan documented the SSD was responsible for these interventions.</p> <p>Review of the Interdisciplinary Progress Notes signed by the SSD revealed no documentation of a discharge and/or readmission for Resident #4. There was no documentation of noncompliance with smoking policies in the SSD notes for Resident #4.</p> <p>4. Medical record review for Resident #5 documented an admission date of 11/21/07 with a re-admission date of 3/7/08 with diagnoses of Hemiplegia, Dysphagia, Anemia, Congestive Heart Failure and Depressive Disorder. Review of a physician's order dated 4/7/10 documented, "...Hospice..." Review of the Social Progress Note for Resident #5 revealed updates on 6/10/09 and 3/1/10. The notes were not updated quarterly. Review of the Social Progress Notes for Resident #5 revealed no documentation that Resident #5</p>	F 250		

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

PRINTED: 05/24/2010
FORM APPROVED
OMB NO. 0938-0391

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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 250	<p>Continued From page 12 was receiving hospice care.</p> <p>5. Medical record review for Resident #8 documented an admission date of 4/15/10 with a readmission date of 5/14/10 and admission diagnoses of Dementia, Subdural Hemorrhage, Mental Disorder and Macular Degeneration of the Retina with Legal Blindness. Review of the Interdisciplinary Progress Notes dated 4/21/10 documented, "5:30 PM resident ^ [up] in dining room alert c [with] confusion resident has been aggressive this pm has been swinging cane @ [at] other residents this afternoon @ 4:45 pm cursing in dining room..." and 4/22/10 documented, "Care Note...Behaviors of aggression..." The only social service note was an admission note dated 4/19/10 and did not address behaviors.</p> <p>During an interview in the Social Service Director's office on 5/18/10 at 2:30 PM, the SSD stated, "...If they [nurses] don't tell me there's a behavior, obviously I can't address it. If I know it [behaviors], I'll address it. I went out on vacation on 4/27 [2010]."</p> <p>6. Medical record review for Resident #19 documented an admission date of 4/13/10 with diagnoses of Muscle Weakness, Pressure Ulcer Buttocks Stage Four, Thrombocythemia, Anemia, Pyelonephritis, Colostomy and Lower Limb Amputation. Review of an "Interdisciplinary Progress Note" for nursing dated, "4/27/10-315A [AM]" documented, "...[Named physician] notified of resident's condition, verbally abusive to ambulance attendants accusing them of handling him roughly. All staff was observing transfer from w/c [wheelchair] to stretcher procedure done mostly by residents. Stretcher being placed in a</p>	F 250		

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

FORM APPROVED
OMB NO. 0938-0391

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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 250	Continued From page 13 sitting position is when he began to yell at the female attendant and curse her." Review of an "Interdisciplinary Progress Note" for nursing dated 5/1/10-1:10 PM- documented, "Pt [patient] OOF [out of facility] requested to go out c [named individual] to [named store]." 5:30 PM- "Pt back to facility 0 [no] problems noted. Pt very sleepy. Pt very slow to respond. Will continue to monitor." 5/2/10-1:20 - "Pt resting quietly. Has slept all day. Notified DON [Director of Nursing] of resident's trip out yesterday and pts [patients] condition noted p [after] return. Noted on sign out sheet that his "friend" had signed [named Resident #19] out under his sister's name. [Named Resident #19] was questioned and he stated I told her to sign my sister's name because I knew she wouldn't be able to take me out. [Named DON] notified of above. Request made for drug test to be given. DON aware of results..." During an interview on the East hall on 5/19/10 at 9:05 AM, the DON was asked about the drug test results for Resident #19. The DON stated, "We do our own [drug] screening here, don't have anything written down on it. I can tell you it was positive for marijuana." There was no documentation in the social worker's notes of any interventions to address Resident #19's behaviors.	F 250		
F 309 SS=E	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 309	<u>F309</u> 1. RI #1 was reassessed and re-evaluated for pain by the Licensed Nurse on May 26, 2010.	

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

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OMB NO. 0938-0391

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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 309	<p>Continued From page 14</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy reviews, medical record review, observations and interviews, it was determined the facility failed to ensure each resident was provided with the necessary care and services to maintain their highest practical well-being when the facility failed to follow their policy for assessments for falls, failed to follow physician's orders and/or failed to perform quarterly nutritional assessments for 5 of 23 (Residents #1, 5, 6, 7 and 16) sampled residents.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Review of the facility's "Falls Management" policy documented "Post-Fall Documentation" After the resident has been cared for, the licensed nurse: 1. Completes an interdisciplinary progress note, including a brief summary of the fall, the nursing evaluation, actions taken, who was notified, and resident's condition (Licensed nurses continue to document the resident's condition in the Interdisciplinary Progress Notes during each shift for the next 24 hours, and daily for the next 72 hours, noting any changes in condition.) ...9. Continues to follow the resident every shift for the next 72 hours; documents findings and resident condition in the Interdisciplinary Progress Notes." <p>Medical record review for Resident #1 documented an admission date of 10/6/06 with diagnoses of Depressive Disorder, Dementia With Behaviors, Anxiety State, Alzheimer's and Dementia. Review of nurses' notes dated</p>	F 309	<p>RI #1 wheelchair alarm and landing strips were re-implemented on May 17, 2010 at 4:30 pm by the Licensed Nurse.</p> <p>Nurse #2 was provided re-education on device placement on May 26, 2010 by the DNS.</p> <p>Nurse #4 is no longer employed by the center.</p> <p>RI #5 and RI #7 were reassessed by the Registered Dietitian on May 28, 2010.</p> <p>RI #7's pressure pad alarm was replaced on May 18, 2010 at 8:35 am by the Licensed Nurse.</p> <p>Nurse #1 was provided re-education on device placement on May 26, 2010 by the Director of Nursing.</p> <p>RI #6's body alarm and landing strips were replaced on May 19, 2010 at 12:15 pm by the Licensed Nurse.</p> <p>C.N.A. #2 received re-education on device placement on May 26, 2010 by the Director of Nursing.</p> <p>RI #16's body alarm and landing strip pads were replaced on May 19, 2010 at 10:30 am by the Licensed Nurse.</p> <ol style="list-style-type: none"> A Pain Assessment Audit was conducted May 26-June 3, 2010 by the 	

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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 309	<p>Continued From page 15</p> <p>10/12/09 "7A 7P" documented "...Also notice (L) [left] knee was swollen. Resident appear to be in some pain when it [left knee] is touched..." There was no further documentation regarding Resident #1's pain until she was assessed by the Director of Nursing (DON) on 10/13/09 and a pain assessment was completed at that time.</p> <p>Review of physician's orders dated 4/29/10 documented, "...Body alarm in wheelchair... landing pads beside bed to floor."</p> <p>Observations in Resident #1's room on 5/17/10 at 4:30 PM, revealed Resident #1 sitting in a wheelchair with no wheelchair alarm in place nor were there any landing pads in place as ordered.</p> <p>Observations in the dining room on 5/18/10 at 8:00 AM, revealed Resident #1 sitting in a wheelchair with no alarm on as ordered.</p> <p>During an interview with Licensed Practical Nurse (LPN) #2 in Resident # 1's room on 5/17/10 at 4:30 PM, LPN #2 stated, "She [Resident #1] has an alarm on the bed but not on her wheelchair."</p> <p>During a telephone interview with Nurse #4 on 5/19/10 at 11:15 AM, Nurse #4 stated, "I was the charge nurse and gave no pain medication other than medication already scheduled and did not notify the physician at the time of the injury. I cannot explain why there were no further nurses notes on the resident [#1]."</p> <p>2. Review of the "MEDICAL NUTRITIONAL THERAPY" policy documented, "...Policy Statement- It is the center policy that a Clinical Dietitian completes a comprehensive nutrition assessment for all residents for the purpose of</p>	F 309	<p>Assistant Director of Nursing and Unit Managers for residents receiving scheduled pain medication regimens and prn pain medication regimens.</p> <p>An MD notification audit was conducted by the Director of Nursing, Assistant Director of Nursing, and Unit Manager on May 26-June 2, 2010 of residents with events over the past 30 days.</p> <p>On May 27, 2010, an audit was conducted by the licensed nurses on devices ordered including body alarms, landing strips, and pressure pad alarms. Attending Physician's were notified of devices not in place per orders on May 27, 2010 by the licensed nurses.</p> <p>A care plan audit was conducted by the MDS Coordinator and Licensed Nurses on May 26-28, 2010 to ensure devices are care planned per physician's orders.</p> <p>The Dietary Manager conducted an audit May 26-28, 2010 of medical records to ensure the Registered Dietitian assessments are current.</p> <p>3. On May 24-27, 2010, staff were re-educated on the following by the Director of Nursing:</p> <ul style="list-style-type: none"> ❖ Timely physician notification with changes in condition 	

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

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 05/19/2010
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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 309	<p>Continued From page 16 identifying and planning the nutrition care needed. Residents' nutritional status will be assessed upon admission and monitored at least quarterly thereafter... 3. The Clinical Dietitian will reassess quarterly and upon referral and when the resident experiences a change in condition..."</p> <p>3. Medical record review for Resident #5 documented an admission date of 11/21/07 with a re-admission date of 3/7/08 with diagnoses of Hemiplegia, Dysphagia, Anemia, Diabetes Mellitus and Congestive Heart Failure. Review of the "Medical Nutrition Therapy Assessment" documented assessments were completed on 6/12/09 and 2/2/10. The "Medical Nutrition Therapy Assessment" for Resident #5 was not completed quarterly as per the facility's policy. The facility was unable to provide documentation of the assessments being done quarterly.</p> <p>4. Medical record review for Resident #7 documented an admission date of 4/28/08 with diagnoses that included Dementia, Alzheimer's Disease, Hypothyroidism and Anxiety. Review of the "Medical Nutrition Therapy Assessment" documented assessments were completed on 7/8/09 and 1/26/10. The "Medical Nutrition Therapy Assessment" for Resident #7 was not completed quarterly as per the facility's policy.</p> <p>Review of the physician's orders dated 4/6/10 for Resident #7 documented, "pressure pad alarm in bed due to poor safety awareness."</p> <p>Observations in Resident #7's room on 5/18/10 at 8:00 AM and 8:30 AM, revealed Resident #7 lying in bed with no pressure pad alarm in the bed as ordered.</p>	F 309	<ul style="list-style-type: none"> ❖ Updating pain assessments with new onset of pain and changes in condition that result in pain ❖ Placement of devices per physician's orders <p>On May 28, 2010, the Registered Dietitian was re-educated by the Regional Dietitian on the policy for completing Nutritional Assessments.</p> <p>4. The Director of Nursing and Assistant Director of Nursing will conduct the Pain Assessment Audits weekly x 4 weeks; then monthly x 2 months to ensure follow-up documentation is completed for new onset episodes of pain and changes in condition that result in pain.</p> <p>The Administrator, Director of Nursing, Staff Development Coordinator, Activities Director, Social Services Director, Maintenance Director, and Nutritional Services Director, Health Information Coordinator, Payroll Coordinator, Unit Supervisor, and A/R Specialist will conduct audits of Devices 3x a week x 4 weeks; then weekly x 2 months to ensure devices are in place per physician's orders.</p> <p>The DNS, ADON, and/or designee will conduct audits of residents with events for appropriate MD</p>	

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

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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 05/19/2010
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 309	<p>Continued From page 17</p> <p>During an interview in Resident #7's room on 5/18/10 at 8:35 AM, Nurse #1 stated she did not see the pressure pad alarm on Resident #7's bed.</p> <p>5. Medical record review for Resident #6 documented an admission date of 8/21/09 with a re-admission date of 3/16/10 with diagnoses of Chronic Kidney Disease, Late Effect Cerebral Vascular Disease and Depressive Disorder. The physician's order dated 4/27/10 documented, "...Body alarm to bed and wheelchair d/t [due/to] poor safety awareness... Landing pads to bedside floor..."</p> <p>Observations in Resident #6's room on 5/18/10 at 2:20 PM, 3:40 PM, 4:00 PM and 5:25 PM, and on 5/19/10 at 12:10 PM, revealed Resident #6 lying in bed with no body alarm attached and no landing pads on the floor at the bedside as ordered.</p> <p>Observations in Resident #6's room on 5/19/10 at 7:45 AM, revealed Resident #6 lying in bed with no landing pads on floor at the bedside as ordered.</p> <p>During an interview in Resident #6's room on 5/18/10 at 4:00 PM, CNA #2 verified that Resident #6 did not have a body alarm on or landing pads on floor at the bedside.</p> <p>During an interview in Resident #6's room on 5/19/10 at 12:10 PM, the Director of Nursing verified that Resident #6 did not have the body alarm in place or landing pads on the floor at the bedside.</p> <p>6. Medical record review of Resident #16 documented an admission date of 9/09/09 with</p>	F 309	<p>notification. The audit will be conducted 3x weekly x 4 weeks; then weekly x 2 months. These findings will be taken to the Performance Improvement Committee Meeting.</p> <p>The Performance Improvement Committee consisting of the Medical Director, Administrator, Director of Nursing, Staff Development Coordinator, Activities Director, Social Services Director, Maintenance Director, and Nutritional Services Director will monitor the results of the Pain Assessment audits, Device Audits, and MD notification audits monthly for three months; subsequent plans of correction will be implemented as necessary based on the audit results.</p>	6/14/2010	

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

PRINTED: 05/27/2010
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 05/19/2010
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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 309	Continued From page 18 diagnoses of Chronic Obstructive Pulmonary Disease, Hemiplegia, Chronic Ischemic Heart Disease, Hypertension, and Osteoarthritis. Review of the physician's orders dated 5/1/10 documented, "body alarm while in bed d/t [due to] poor safety awareness... landing pads beside bed on floor." Observations in Resident #16's room on 5/19/10 at 10:20 AM, revealed no body alarm and no landing pad in place as ordered. During an interview with the DON in Resident # 16's room on 5/19/10 at 10:30 AM, the DON was unable to locate the body alarm. Resident #6 stated, "I have never had one [body alarm]." The DON was unable to locate a landing pad in the room.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations and an interview, it was determined the facility failed to position catheter tubing correctly by allowing the catheter tubing to touch the floor for 1 of 3 (Resident #9) sampled	F 315	<u>F315</u> 1. Catheter tubing for RI #9 was repositioned on May 18, 2010 to prevent the tubing from touching the floor. 2. Licensed nurses completed audits on May 18, 2010 of residents requiring catheters to ensure proper positioning of tubing. 3. Staff, to include licensed nurses and CNA's were re-educated on May 18-27, 2010 by the Director of Nursing Services regarding proper positioning of tubing to prevent the spread of infection.	

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

PRINTED: 05/24/2010
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 05/19/2010
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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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(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 315	<p>Continued From page 19 residents with a Foley catheter.</p> <p>The findings included:</p> <p>Observations in Resident #9's room on 5/18/10 at 12:15 PM, revealed Resident #9's catheter tubing was touching the floor.</p> <p>During an interview in Resident's #9's room on 5/18/10 at 12:15 PM, the Director of Nursing (DON) stated, "I will take care of it [the catheter tubing touching the floor]."</p> <p>Observations in Resident #9's room on 5/18/10 at 5:08 PM, revealed Resident #9's catheter tubing was touching the floor.</p> <p>Observations in Resident #9's room on 5/18/10 at 5:35 PM, revealed Resident #9's catheter tubing was touching the floor.</p>	F 315	<p>4. The Administrator, Director of Nursing, Staff Development Coordinator, Activities Director, Social Services Director, Maintenance Director, and Nutritional Services Director, Health Information Coordinator, Payroll Coordinator, Unit Supervisor, and Accounts Receivable Specialist will audit tubing three x weekly x four weeks, two x weekly x four weeks, and weekly x one month and report the findings to the Performance Improvement Committee.</p> <p>The Performance Improvement Committee consisting of the Medical Director, Administrator, Director of Nursing, Staff Development Coordinator, Activities Director, Social Services Director, Maintenance Director, and Nutritional Services Director will monitor the results of the Customer First Rounds for three months; subsequent plans of correction will be implemented as necessary based on the audit results.</p>	
F 332 SS=E	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>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, medical record review and observations, it was determined the facility failed to ensure 3 of 3 (Nurses #1, 2 and 3) nurses administered medications with a medication error rate of less than 5 percent (%) on 1 of 3 (evening shift) shifts. A total of 4 errors were observed out of 40 opportunities for error</p>	F 332	<p><u>F332</u></p> <p>1. RI #22 was evaluated for S/S of hyper/hypoglycemia by the Licensed</p>	6/14/2010

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F 332	<p>Continued From page 20</p> <p>resulting in a medication error rate of 10%. The facility failed to ensure insulin was administered correctly in relation to meals.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Review of the "MED-PASS COMMON INSULINS: Pharmacokinetics, Compatibility, and Properties" provided by the American Society of Consultant Pharmacist for typical dosing administration of insulin related to meals documented, "Novolin R [Regular] ...TYPICAL DOSING/COMMENTS ...30 minutes before meals..." Medical record review of the physician's orders for Resident #22, dated 5/1/10, documented an order for Regular Insulin before meals (AC) and at bedtime (HS) daily at 6:00 AM, 11:30 AM, 4:30 PM and 9:00 PM with sliding scale per accucheck results. The sliding scale dosage for accucheck results of 140- [to] 179 was 2 units (U). <p>Observations in Resident #22's room on 5/18/10 at 4:15 PM revealed Nurse #1 administered 2U of Novolin R insulin to Resident #22. Resident #22 was not served her dinner meal until 5:27 PM. The administration of the Novolin R more than 30 minutes before the meal resulted in medication error #1.</p> <ol style="list-style-type: none"> Medical record review of the physician's orders for Random Resident (RR) #1, dated 4/29/10, documented an order for Novolin R AC and HS daily at 6:00 AM, 11:00 AM, 4:30 PM and 9:00 PM per sliding scale following accucheck. The sliding scale dosage documented for accucheck results of 281-290 was 9U. 	F 332	<p>Nurse on 5/18/10 at 6:00 pm and there were no issues identified.</p> <p>RR#1 was reevaluated for S/S of hyper/hypoglycemia on 5/19/10 at 6:00 pm and there were no issues identified.</p> <p>RR#2 was reevaluated for SS of hyper/hypoglycemia on 5/19/10 at 6:00 pm and there were no issues identified.</p> <p>RR#3 was reevaluated for SS of hyper/hypoglycemia on 5/19/10 at 6:00 pm and there were no issues identified.</p> <p>2. An audit of blood sugars was conducted by the Licensed Nurses on May 19, 2010 of residents receiving sliding scale insulin.</p> <p>On June 4th, 2010 an audit of Diabetic residents was completed by the Director of Nursing and Assistant Director of Nursing of residents receiving insulin medication were provided with food within 30 minutes of insulin administration.</p> <p>3. The Staff Development Coordinator re-educated Licensed Nurses on May 27, 2010 on Insulin Administration and providing food within 30 minutes of insulin therapy.</p>	

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F 332	Continued From page 21 Observations in RR #1's room on 5/19/10 at 4:07 PM revealed Nurse #2 administered 9U Novolin R to RR #1. Observations on 5/19/10 at 4:55 PM revealed RR #1 had not yet received a dinner tray. The administration of the Novolin R more than 30 minutes before the meal resulted in medication error #2. 4. Medical record review of the physician's orders for RR #2, dated 5/1/10, documented an order for Regular Insulin AC and HS daily at 6:00 AM, 11:30 AM, 4:30 PM and 9:00 PM per sliding scale following accucheck. The sliding scale dosage for accucheck results of 200-249 was 5U. Observations in RR #2's room 5/19/10 at 4:55 PM revealed Nurse #2 administered 5U Novolin R to RR #2. Observations on 5/19/10 at 5:25 PM revealed RR #2 had not yet received a dinner tray. The administration of the Novolin R more than 30 minutes before the meal resulted in medication error #3. 5. Medical record review of the physician's orders for RR #3, dated 3/13/10, documented an order Regular Insulin per sliding scale following accucheck. The sliding scale dosage for accucheck results of 211-220 was 2 units. Observations in RR #3's room on 5/19/10 at 4:30 PM revealed Nurse #3 administered 2U Novolin R to RR #3. Observations on 5/19/10 revealed RR #3 did not receive a dinner tray until 5:16 PM. The administration of the Novolin R more than 30 minutes before the meal resulted in medication error #4.	F.332	4. The Director of Nursing and Staff Development Coordinator will conduct Medication Administration Pass Competencies with licensed nurses two times per week for four weeks, then weekly for four weeks, and then monthly for one quarter to ensure medications are administered according to the physician orders and the audits will be documented. The Director of Nursing will review and analyze the results of the audits monthly in the Performance Improvement Committee meeting attended by the Medical Director, Administrator, Director of Nursing, Staff Development Coordinator, Activities Director, Social Services Director, Maintenance Director, and Nutritional Services Director for one quarter. Subsequent plans of correction will be implemented as necessary.	6/14/2010
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333	F333	

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F 333	<p>Continued From page 22</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>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, medical record review and observations, it was determined the facility failed to ensure residents were free of significant medication errors. During observations of the medication administration 3 of 3 (Nurses #1, 2 and 3) nurses on 1 of 3 (evening shift) shifts failed to administer insulin within the proper timeframe before meals.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Review of the "MED-PASS COMMON INSULINS: Pharmacokinetics, Compatibility, and Properties" provided by the American Society of Consultant Pharmacist for typical dosing administration of insulin related to meals documented, "Novolin R [Regular]... TYPICAL DOSING/COMMENTS... 30 minutes before meals..." Medical record review of the physician's orders for Resident #22, dated 5/1/10, documented an order for Regular Insulin before meals (AC) and at bedtime (HS) daily at 6:00 AM, 11:30 AM, 4:30 PM and 9:00 PM with sliding scale per accucheck results. The sliding scale dosage for accucheck results of 140- [to] 179 was 2 units (U). <p>Observations in Resident #22's room 5/18/10 at 4:15 PM revealed Nurse #1 administered 2U of Novolin R insulin to Resident #22. Resident #22</p>	F 333	<ol style="list-style-type: none"> RI #22 was evaluated for S/S of hyper/hypoglycemia by the Licensed Nurse on 5/18/10 at 6:00 pm and there were no issues identified. RR#1 was reevaluated for S/S of hyper/hypoglycemia on 5/19/10 at 6:00 pm and there were no issues identified. RR#2 was reevaluated for SS of hyper/hypoglycemia on 5/19/10 at 6:00 pm and there were no issues identified. RR#3 was reevaluated for SS of hyper/hypoglycemia on 5/19/10 at 6:00 pm and there were no issues identified. An audit of blood sugars was conducted by the Licensed Nurses on May 19, 2010 of residents receiving sliding scale insulin. On June 4th, 2010 an audit of Diabetic residents was completed by the Director of Nursing and Assistant Director of Nursing of residents receiving insulin medication were provided with food within 30 minutes of insulin administration. The Staff Development Coordinator re-educated Licensed Nurses on May 27, 2010 on Insulin 	

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F 333	<p>Continued From page 23</p> <p>was not served her dinner meal on 5/18/10 until 5:27 PM. The administration of the Novolin R more than 30 minutes before the meal resulted in a significant medication error.</p> <p>3. Medical record review of the physician's orders for Random Resident (RR) #1, dated 4/29/10, documented an order for Novolin R AC and HS daily at 6:00 AM, 11:00 AM, 4:30 PM and 9:00 PM per sliding scale following accucheck. The sliding scale dosage documented for accucheck results of 281-290 was 9U.</p> <p>Observations in RR #1's room 5/19/10 at 4:07 PM revealed Nurse #2 administered 9U Novolin R to RR #1. Observations on 5/19/10 at 4:55 PM revealed RR #1 had not yet received a dinner tray. The administration of the Novolin R more than 30 minutes before the meal resulted in a significant medication error.</p> <p>4. Medical record review of the physician's orders for RR #2, dated 5/1/10, documented an order for Regular Insulin AC and HS daily at 6:00 AM, 11:30 AM, 4:30 PM and 9:00 PM per sliding scale following accucheck. The sliding scale dosage for accucheck results of 200-249 was 5U.</p> <p>Observations in RR #2's room 5/19/10 at 4:55 PM revealed Nurse #2 administered 5U Novolin R to RR #2. Observations on 5/19/10 at 5:25 PM revealed RR #2 had not yet received a dinner tray. The administration of the Novolin R more than 30 minutes before the meal resulted in a significant medication error.</p> <p>5. Medical record review of the physician's orders for RR #3, dated 3/13/10, documented an order for Regular insulin per sliding scale following</p>	F 333	<p>Administration and providing food within 30 minutes of insulin therapy.</p> <p>4. The Director of Nursing and Staff Development Coordinator will conduct Medication Administration Pass Competencies with licensed nurses two times per week for four weeks, then weekly for four weeks, and then monthly for one quarter to ensure medications are administered according to the physician orders and the audits will be documented.</p> <p>The Director of Nursing will review and analyze the results of the audits monthly in the Performance Improvement Committee meeting attended by the Medical Director, Administrator, Director of Nursing, Staff Development Coordinator, Activities Director, Social Services Director, Maintenance Director, and Nutritional Services Director for one quarter. Subsequent plans of correction will be implemented as necessary.</p>	6/14/2010

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F 333	Continued From page 24 accucheck. The sliding scale dosage for accucheck results of 211-220 was 2U. Observations in RR #3's room on 5/19/10 at 4:30 PM revealed Nurse #3 administered 2U Novolin R to RR #3. Observations revealed RR #3 did not receive a dinner tray on 5/19/10 until 5:16 PM. The administration of the Novolin R more than 30 minutes before the meal resulted in a significant medication error.	F 333		
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 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431	F431 1. Licensed Nurse #1 immediately removed the Milk of Magnesia from resident's room on May 17, 2010. Resident in room 27B was reassessed on May 19, 2010 with no abnormal findings. 2. Licensed nurses completed an audit of resident's room on May 27, 2010, to check for unsecured medications. A letter was mailed by the Administrator to residents and families on June 2, 2010, regarding security of medications and proper storage of medications. 3. Staff to were re-educated by June 4, 2010 by the Staff Development Coordinator regarding proper security of medications.	

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F 431	Continued From page 25 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 observation and interview, it was determined the facility failed to secure medications in 1 of 3 (East hall) halls. The findings included: Observations in Room 27B, located on the East hall, on 5/17/10 at 11:45 AM, revealed a bottle of Phillips Milk of Magnesia (MOM) was sitting on the over bed table for B bed in room 27. During an interview in Room 27B on 5/17/10 at 12:00 AM, Licensed Practical Nurse #1 stated, "He [Resident in room 27B] left yesterday and that's probably when he got it [MOM]."	F 431	4. The Performance Improvement Committee consisting of the Medical Director, Administrator, Director of Nursing, Staff Development Coordinator, Activities Director, Social Services Director, Maintenance Director, and Nutritional Services Director will monitor resident's rooms 3x weekly x 3 months. The results of the audits will be reviewed by the Performance Improvement Committee and subsequent plans of correction will be implemented as necessary based on the audit results.	6/14/2010
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441	F441 1. C.N.A.#3 received hand-washing re-education on May 26, 2010 by the Director of Nursing. C.N.A. #1 received hand-washing re-education on May 26, 2010 by the Director of Nursing. Resident in room 23B was reassessed on 5/25/2010 by the Director of	

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F 441	<p>Continued From page 26</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the "Long-Term Care Pocket Guide for Infection Control" and observations, it was determined 2 of 3 Certified Nursing Assistants (CNAs #1 and 3) observed failed to ensure infection control practices were used to prevent the spread of infections by not washing hands after direct resident contact.</p> <p>The findings included:</p> <p>1. Review of the "Long Term Care Pocket Guide</p>	F 441	<p>Nursing Services and there was no changes in condition.</p> <p>Resident in Room 33 was reassessed on 5/25/2010 by the Director of Nursing Services and there was no change in condition.</p> <p>2. Nursing Management consisting of the Director of Nursing Services, Staff Development Coordinator, and Unit Managers performed audits of hand-washing techniques June 3-June 4, 2010.</p> <p>3. Staff was reeducated by the Staff Development Coordinator on May 27-June 2 regarding proper hand washing techniques.</p> <p>4. Nursing Management consisting of the Director of Nursing Services, Staff Development Coordinator, and Unit Managers will perform audits 3 x weekly x 4 weeks, 2 x weekly x 4 weeks, then 1 x weekly x 4 weeks to observe hand washing compliance. Infractions of non-compliance will result in one-to-one education.</p> <p>The Performance Improvement Committee consisting of the Medical Director, Administrator, Director of Nursing, Staff Development Coordinator, Activities Director, Social Services Director, Maintenance Director, and Nutritional Services</p>	

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F 441	Continued From page 27 for Infection Control" copyright 2008, page 49 documented, "...Handwashing is the single most important thing you can do to prevent the spread of infection. Thorough handwashing removes pathogens from the skin. Wash hands before and after all client or body fluid contact... Decontaminate hands before having direct contact with residents... Decontaminate hands after contact with a resident's intact skin... Decontaminate hands after contact with inanimate objects... in the immediate vicinity of the resident..."	F 441	Director will monitor the results of the Infection Control Walk Rounds for three months; subsequent plans of correction will be implemented as necessary based on the audit results.	6/14/2010
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465	465 1. The front lobby area and North Hall were cleaned on May 19, 2010 by the Housekeeping Supervisor.	

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F 465	Continued From page 28 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 observations, it was determined the facility failed to ensure the environment was free of strong ammoniacal (urine) odors in 2 of 6 (Front lobby and North hall) common areas. The findings included: 1. Observations in the front lobby on 5/17/10 at 11:30 AM, revealed strong urine odors. Observations in the front lobby on 5/18/10 at 7:30 AM, revealed strong urine odors. Observations in the front lobby on 5/19/10 at 7:45 AM, revealed strong urine odors. 2. Observations on the North hall on 5/17/10 at 12:30 PM, revealed strong urine odors. Observations on the North hall on 5/18/10 at 7:45 AM, revealed strong urine odors. Observations on the North hall on 5/19/10 at 7:45 AM, revealed strong urine odors. Observations on the North hall on 5/19/10 at 1:15 PM, revealed strong urine odors.	F 465	2. An audit was conducted by the Administrator and Housekeeping Supervisor on May 27, 2010 to identify sources of odors. Nursing Management to include the Director of Nursing Services, Staff Development Coordinator, Unit Managers, and Administrator completed a walk through audit on May 27, 2010 to identify source of odors. 3. Staff was re-educated by the Staff Development Coordinator on May 27-June 2, 2010 regarding identification and resolution of odors. 4. Nursing Management to include the Director of Nursing Services, Staff Development Coordinator, Unit Managers, and Administrator will complete a walk through audit of center 3 x weekly x 4 weeks, 2 x weekly x 4 weeks, and 1 x weekly x 4 weeks to identify/resolve source of odors.	
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests	F 469		

The Performance Improvement Committee consisting of the Medical Director, Administrator, Director of Nursing, Staff Development Coordinator, Activities Director, Social Services Director, Maintenance Director, and Nutritional Services Director will monitor the results of the Environmental Walk Rounds for three months; subsequent plans of correction will be implemented as necessary based on the audit results.

6/14/2010

292 of 32

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 05/19/2010
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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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(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 469	<p>Continued From page 29 and rodents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, it was determined the facility failed to ensure the environment was free of flies in 1 of 3 (North Hall) halls, 1 of 38 resident rooms (room 30B), the dining room, the nurses station and the laundry.</p> <p>The findings included:</p> <p>1. Observations in the dining room on 5/17/10 at 12:30 PM, revealed flies, flying around the tables.</p> <p>Observations in the dining room on 5/18/10 at 11:00 AM, revealed flies, flying around the tables.</p> <p>2. Observations on the North hall on 5/17/10 at 1:30 PM, revealed the presence of flies.</p> <p>Observations on the North hall on 5/19/10 at 1:15 PM, revealed the presence of flies.</p> <p>3. Observations in the nurses station on 5/17/10 at 4:50 PM, revealed the presence of flies.</p> <p>Observations in the nurses station on 5/18/10 at 12:10 PM, revealed the presence of flies.</p> <p>Observations in the nurses station on 5/19/10 at 8:10 AM, revealed the presence of flies.</p> <p>Observations in the nurses station on 5/19/10 at 12:00 PM, revealed the presence of flies.</p> <p>4. Observations in resident room 30B on 5/18/10</p>	F 469	<p><u>F469</u></p> <p>1. Eradication of the flies was completed by May 27-June 4, 2010 by the Housekeeping and Maintenance Departments.</p> <p>2. Maintenance Director contacted Pest Control Provider regarding increased servicing for flies. Provider provided first treatment May 28, 2010.</p> <p>Administrator submitted a purchase order on May 25, 2010 for three air curtains to be installed on the front entrance, back entrance, and kitchen entrance upon delivery.</p> <p>Treatment of flies was completed on May 28, 2010 by the Pest Control Provider.</p> <p>3. Re-education was conducted for the facility staff by the Staff Development Coordinator and Maintenance Department on May 27, 2010, for the reporting of pests.</p> <p>4. The Administrator, Director of Nursing, Staff Development Coordinator, Activities Director, Social Services Director, Maintenance Director, and Nutritional Services Director, Health Information</p>	

Coordinator, Payroll Coordinator, Unit Supervisor, and A/R Specialist will monitor for fly activity in residents rooms, laundry, and common areas 3 times weekly x 4 weeks and 1 x weekly x 2 months.

The Performance Improvement Committee consisting of the Medical Director, Administrator, Director of Nursing, Staff Development Coordinator, Activities Director, Social Services Director, Maintenance Director, and Nutritional Services Director will monitor the results of the Customer First Rounds for three months; subsequent plans of correction will be implemented as necessary based on the audit results.

6/14/2010

30A of 32

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 05/19/2010
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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 469	Continued From page 30 at 7:55 AM, revealed a fly crawling on Resident #9's breakfast tray.	F 469		
F 502 SS=D	5. Observations in the laundry room on 5/18/10 at 10:00 AM, revealed the presence of flies in both the soiled and clean linen areas. 483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY 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 laboratory (lab) testing was done in a timely manner for 2 of 23 (Residents #9 and 12) sampled residents. The findings included: 1. Medical record review for Resident #9 documented an admission date of 1/6/10 with diagnoses of Coronary Artery Disease, Dementia, Cardiovascular Accident, Diabetic Neuropathy and Diabetes Mellitus. A physician's order dated 3/30/10 documented, "U/A [urinalysis] with C/S [culture and sensitivity] in AM." The facility was unable to provide results for the UA with C/S. During an interview in the Director of Nursing's (DON) office on 5/19/10 at 10:20 AM, the DON stated, the UA with C/S test had not been completed as ordered.	F 502	F502 1. RI #9 was reassessed by the licensed nurse on May 18, 2010 and U/A was obtained. Attending physician was contacted and notified by the Licensed nurse on May 18, 2010 RI #12 was reassessed and received CBC's on May 3, 10, 17, and 24. Attending physician was contacted by the Licensed Nurse on May 25, 2010. 2. Lab audits for May 27 - June 13, 2010 are to be completed by Director of Nursing Services, Assistant Director of Nursing, and Unit Manager. 3. Licensed nurses were re-educated by the Director of Nursing Services and Staff Development Coordinator on May 18-27, 2010 regarding the lab tracking system. 4. The Director of Nursing Services and Staff Development Coordinator will conduct lab audits two times per week for four weeks, then weekly for four weeks, and then monthly for one	

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F 502	Continued From page 31 2. Medical record review for Resident #12 documented an admission date of 2/12/06 with diagnoses of Dysphagia, Congestive Heart Failure, Catatonia and Depressive Anxiety. Review of a physician's order dated 8/5/09 and updated 5/1/10 documented, "...Weekly CBC [Complete Blood Count]..." Review of the lab testing results revealed a CBC was not done for the weeks of August 10, 2009; September 7, 14, 21 and 28, 2009; October 19, 2009; November 9 and 16, 2009; March 22, 2010 and April 12, 2010. During an interview in the DON's office on 5/19/10 at 10:20 AM, the DON stated, "Can't find those labs [CBC] on [Named Resident #12]."	F 502	month to ensure labs are administered according to the physician orders. The Director of Nursing will review and analyze the results of the audits monthly in the Performance Committee meeting attended by the Medical Director, Administrator, Director of Nursing, Staff Development Coordinator, Activities Director, Social Services Director, Maintenance Director, and Nutritional Services Director for one quarter. Subsequent plans of correction will be implemented as necessary.	6/14/2010