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FORM APPROVED  
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445321</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/12/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>ARDMORE HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>25385 MAIN STREET ARDMORE, TN 38449</b>	
(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 160 SS=D	<p><b>483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH</b></p> <p>Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, review of resident statement account balances, and interview, the facility failed to refund 1 of 1 (Resident #68) deceased resident balance to the resident's estate within thirty days.</p> <p>The findings included:</p> <p>The facility's patient fund policy documented, "...In the event of your death, the Facility will promptly give a full accounting of any personal funds deposited by you with the Facility to the individual administering your estate, and will pay the funds to the individual administering your estate within thirty days..."</p> <p>Medical record review revealed Resident #1 expired on 3/13/15.</p> <p>Review of the resident statement revealed Resident #68 had a balance of \$273.16 and the balance had not been approved to be transferred to the resident's estate until 9/29/15. The balance had not been transferred to the resident's estate within 30 days of the resident's death.</p> <p>Interview with the Business Office Manager</p>	F 160	<ol style="list-style-type: none"> <li>1. Resident #68's balance was transferred to their estate on 9/29/2016. The BOM was in-serviced on 1-13-2016 and 1-26-2016 on the time frame in which refunds must be issued to the estate of a resident in the event of their discharge by the Administrator.</li> <li>2. There was an audit conducted on 1-13-2016 to identify any other residents that were not refunded properly and refunds were issued as they were identified. All discharging residents could potentially be affected by this deficient practice.</li> <li>3. The Administrator or designee will conduct weekly audits for four weeks and then monthly for three months to ensure discharged residents are being refunded within 30 days of their discharge date.</li> <li>4. The Administrator or the Director of Nurses will compile the audit results and present to the monthly Quality Assurance Performance Improvement Committee (Members include:</li> </ol>	<b>1-29-2016</b>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Brandon R. Whiteside*

*Administrator*

*1-29-16*

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 POC was faxed to 615/116 JP PHNCZ*

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F 160  F 278 SS=D	<p>Continued From page 1 (BOM) on 1/12/16 at 12:50 PM, in the admission office, the BOM was asked why the refund was not processed until 9/29/15. The BOM stated, "It was either because I got behind, or because it took me a while to get it right."</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 160  F278=D	<p>Committee Chairperson – Administrator; Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) for 4 months for further recommendations and/or follow up as needed.</p> <ol style="list-style-type: none"> <li>Residents #26, 37, and 51's assessment's were reviewed for accuracy on 1-12-2016.</li> <li>A random audit of assessments will be completed to identify others that could have assessments that were not accurate by 1-29-2016. A performance improvement plan was put in place to ensure by the Minimum Data Set Coordinator to address identified issues going forward. Identified assessments were updated to reflect the residents current care needs. All</li> </ol>	1-29-2016	

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F 278	<p>Continued From page 2</p> <p>by: Based on medical record review, observation, and interview, the facility failed to accurately assess residents for Activities of Daily Living (ADLS), dental problems and/or behaviors for 3 of 10 (Residents #26, 37, and 51) sampled residents reviewed of the 24 residents included in the stage 2 review.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. Medical record review revealed Resident #26 was admitted to the facility on 4/8/14 and readmitted on 2/24/15 with diagnoses of Chronic Diastolic Congestive Heart Failure, Shortness of Breath, Muscle Weakness, Dysphagia, Type 2 Diabetes Mellitus, Anxiety Disorder, Psychotic Disorder, Alzheimer's Disease, Orthostatic Hypotension, Chronic Pulmonary Edema, Acute Kidney Failure, Edema, Malaise, Urinary Tract Infection, Recurrent Dislocation Unspecific knee and Above Knee Amputation.</li> </ol> <p>The annual Minimum Data Set (MDS) dated 9/8/15 documented a Brief Interview Mental Status (BIMS) score of 2 indicating the resident was severely cognitively impaired and bed mobility, transfer, dressing, eating and toilet use were coded as requiring extensive assistance for functional status.</p> <p>The quarterly MDS dated 12/01/15 documented a BIMS score of 2 indicating the resident was severely cognitively impaired and bed mobility, transfer, eating, dressing, toilet use was coded as requiring total dependence for functional status.</p> <p>Interview with the MDS Coordinator on 1/12/16 at 9:15 AM, in the MDS office, the MDS Coordinator</p>	F 278	<p>residents could potentially be affected by this deficient practice.</p> <ol style="list-style-type: none"> <li>3. The Minimum Data Set Coordinator will conduct two random audits weekly for four weeks to ensure compliance and then monthly for three months to ensure assessments accurately reflect the residents current care needs.</li> <li>4. The Administrator or Director of Nurses will compile the audit results and present them to the monthly Quality Assurance Performance Improvement Committee (Members include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) for 4 months further recommendations and/or follow up as needed.</li> </ol>		

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F 278	<p>Continued From page 3</p> <p>was asked if Resident #26 had a decline in her ADLS or what caused the decline. The MDS Coordinator stated, "The problem is coding incorrectly and the discrepancy in charting of the ADLS by the CNAs [certified nurses assistants] that I have found since I came here. There has not being a decline in ADLS and I know because I provided care for her before I took this position."</p> <p>Interview with Director of Nursing (DON) on 1/12/16 at 9:30 AM, in the nursing administration office, the DON was asked if the facility had identified any issues with documentation of decline with ADLS. The DON stated, "There is some inconsistency on charting and documentation of ADLS and tracking. Night shift is invariably inconsistent with documentation."</p> <p>Interview with restorative CNA on 1/12/16 at 9:45 AM, at the nurses' station, the Restorative CNA was asked if Resident #26 had a decline in her ADL status. The Restorative CNA stated, "No, she had not had a decline."</p> <p>Interview with CNA #1 on 1/12/16 at 1:15 PM, on the north hall, CNA #1 was asked if she had noticed a decline in her [Resident #26] level of care. CNA #1 stated, "No, not in the last 2 months that I have been here."</p> <p>2. Medical record review revealed Resident #37 was admitted to the facility on 4/23/13 and readmitted on 1/7/16 with diagnoses of Iron Deficiency Anemia, Quadriplegia, Neoplasm of Uncertain Behavior of the Brain, Severe Protein-Calorie Malnutrition, Mood Disorder, Opioid Dependence, Anxiety Disorder, Depressed Mood, Insomnia, Epilepsy, Migraine, Chronic Pain, Hypertension, Phlebitis and</p>	F 278			

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F 278	<p>Continued From page 4</p> <p>Thrombophlebitis of Popliteal Vein, Pressure Ulcer of Sacral Region, Pressure Ulcer of Right Hip, Pressure Ulcer of Left Hip, Contracture, Muscle Weakness, Chronic Cystitis, Urinary Tract Infection, Dysphagia, Lack of Coordination Edema, Adult Failure to Thrive, Gastrostomy, Colostomy, and Artificial Openings of Urinary Tract.</p> <p>The annual MDS dated 10/13/15 and the quarterly MDS dated 12/2/15 documented no dental problems.</p> <p>Observations in Resident #37's room on 1/12/16 at 7:58 AM, revealed Resident #37 had broken front teeth.</p> <p>Interview with the MDS Coordinator on 1/12/16 at 9:25 AM, in the MDS office, the MDS Coordinator was asked if the dental section was coded correctly. The MDS Coordinator stated, "That is not accurate for him."</p> <p>3. Medical record review revealed Resident #51 was admitted to the facility on 10/7/14, with diagnoses of Alzheimer's Disease, Osteoarthritis, Abnormal Posture, Dementia without Behavioral Disturbance and Hypothyroidism.</p> <p>The weekly summaries dated 12/5/15, 12/12/15, 12/19/15, 12/26/15, 1/2/16 and 1/9/16 documented, "...Behavior Symptoms... [checked] none exhibited..."</p> <p>A significant change MDS dated 6/22/15 documented a (BIMS) of 0 indicating severe cognitive impairment and "Rejection of care: presence and frequency... Behavior of this type occurred 1 to 3 days..."</p>	F 278			

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F 278	Continued From page 5  The quarterly MDS dated 12/8/15 documented, a BIMS of 0 indicating severe cognitive impairment and "Rejection of care: presence and frequency... 0 Behavior not exhibited..."  Interview with the Social Service Director (SSD) on 1/11/16 at 2:55 PM, at the nurses' desk, the SSD was asked if Resident #51 had any behavioral monitoring sheets. The SSD stated, "She does not have behaviors."	F279=D	<ol style="list-style-type: none"> <li>1. Resident #26's care plan was reviewed and updated on 1-14-2016 by the Minimum Data Set Coordinator to ensure the residents care plan was comprehensive to the residents care needs.</li> <li>2. A random audit of care plans was completed on 1-27-2016 to identify others that could have care plans that are not comprehensive. Identified care plans were updated to reflect the residents current care needs. All residents could potentially be affected by this deficient practice. The Minimum Data Set Coordinator was in serviced on accurately completing care plans on 1-26-2016 by the Administrator. The nursing staff will be in serviced by 1-29-2016 on the same by the DON or Staff Development Coordinator.</li> <li>3. The Minimum Data Set Coordinator will conduct two random audits weekly for four weeks to ensure compliance and</li> </ol>	<b>1-29-2016</b>	
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by:</p>				

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F 279	<p>Continued From page 6</p> <p>Based on policy review, medical record review and interview, the facility failed to develop a comprehensive care plan related to Activities of Daily Living (ADLS) for 1 of 10 (Resident #26) sampled residents reviewed of the 24 residents included in the stage 2 review.</p> <p>The findings included:</p> <p>The facility's "Care Plan- Comprehensive" policy documented, "...An individualized care plan that includes measurable objectives and timetables to meet the residents's medical, nursing, mental and psychological needs is developed for each resident... 3. Each resident's comprehensive care plan is designed to... g. Aid in preventing or reducing declines in the resident's functional status and/or functional levels..."</p> <p>Medical record review revealed Resident #26 was admitted to the facility on 4/8/14 and readmitted on 2/24/15 with the diagnoses of Chronic Diastolic Congestive Heart Failure, Shortness of Breath, Muscle Weakness, Dysphagia, Type 2 Diabetes Mellitus, Anxiety Disorder, Psychotic Disorder, Alzheimer's Disease, Orthostatic Hypotension, Chronic Pulmonary Edema, Acute Kidney Failure, Edema, Malaise, Urinary Tract Infection, Recurrent Dislocation Unspecific Knee and Above Knee Amputation.</p> <p>The annual Minimum Data Set (MDS) dated 9/8/15 documented Brief Interview Mental Status (BIMS) score of 2 indicating severe cognitively impaired and bed mobility, transfer, dressing, eating and toilet use were coded as requiring extensive assistance for functional status.</p> <p>The care plan dated 12/9/15 did not include a</p>	F 279	<p>then monthly for three months to ensure assessments accurately reflect the residents current care needs.</p> <p>4. The Administrator or Director of Nurses will compile the audit results and present to the monthly Quality Assurance Performance Improvement Committee (Members include: Committee Chairperson – Administrator; Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) for 4 months for further recommendations and/or follow up as needed.</p>		

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F 279	Continued From page 7 care plan for ADLS.  Interview with MDS Coordinator on 1/12/16 at 9:00 AM, in the MDS office, MDS Coordinator was asked if Resident #26 should have a care plan for ADLS. MDS Coordinator stated, "Yes, and when I came in on 11/15 I have found missing care plans."  Interview with Director of Nursing (DON) on 1/12/16 at 2:20 PM, in the nursing administration office, the DON was asked if Resident #26 should have had a care plan for ADLS. The DON stated, "Yes, definitely. I think everyone here should have a care plan for ADLS."	F332=E	1. Resident #26 and Resident #48 suffered no adverse outcomes related to insulin administration and subsequent medication errors. LPN #1 and LPN #3 were educated on properly identifying current physician orders pertaining to all medications that are to be administered by 1-29-2016.  Resident #47 suffered no adverse outcomes related to the miss of administration of Miralax. Resident #47 had received the dose of Miralax the day before the medication pass observation, according to the MAR (1-11-2016). LPN #1 was educated on properly identifying current physician orders pertaining to all medications that are to be administered. LPN #1 was also in-serviced on the need to write an order to "Hold" an administration of an unavailable medication until available from pharmacy on 1-26-2016.  Resident #50 suffered no adverse outcome related to the	1-29-2016	
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on review of the Geriatric medication handbook provided by the American Society of Consultant Pharmacists, policy review, medical record review, observation and interview, the facility failed to ensure 2 of 3 (Licensed Practical Nurses (LPN) #1 and 3) nurses administered medications with a medication error rate of less than 5 percent (%). A total of 6 errors were observed out of 34 opportunities, resulting in an error rate of 17.6%.  The findings included:				

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F 332	<p>Continued From page 8</p> <p>1. The facility's "Insulin Administration" policy documented, "...The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order... The four types of insulin and their characteristics are... Rapid-acting... Onset... 10- [to] 15 min [minutes]... Peak... 0.5-3 hrs [hours]..."</p> <p>The Geriatric medication handbook, eleventh edition, provided by the American Society of Consultant Pharmacists documented, "DIABETES: INJECTABLE MEDICATIONS... Humalog... Rapid-Acting Insulin Analog... ONSET... 15 min [minutes]... PEAK (Hours)... 0.5-1.5... TYPICAL ADMINISTRATION / COMMENTS... 15 minutes prior to meals..."</p> <p>a. Medical record review revealed Resident #26 was admitted to the facility on 4/8/14, with diagnoses of Chronic Congestive Heart Failure, Shortness of Breath, Generalized Muscle Weakness, Dysphagia, Diabetes, Alzheimer's Disease, and Depression.</p> <p>The physician's orders dated 12/11/15 documented, "...NOVOLOG... INJECT 12 UNITS SUB-Q [subcutaneous] TWICE DAILY... 11:30AM... 4:30PM..."</p> <p>Observations in Resident #26's room on 1/10/16 at 4:10 PM, revealed LPN #1 administered Humalog 20 units subcutaneous (SQ) to Resident #26's abdomen. Resident #26 did not receive a meal until 35 minutes later when her son brought her meal tray to her room on 1/10/16 at 4:45 PM.</p>	F 332	<p>medication error that occurred during her gastrostomy tube medication administration and LPN # 3 was observed by the DON performing the same skill on the same resident on 1-13-16 to ensure compliance. No additional medication errors were observed during the observation.</p> <p>2. No other medication errors were identified during the medication pass observation. All residents receiving insulin are potentially affected by similar deficient practices. All nurses were educated by the Director of Nursing or the Staff Development Coordinator for medication administration policies including medication pass competency test and observation. All current insulin medication orders were verified as current by the Unit Manager following most recent survey on 1-26-2016</p> <p>No other missing medications were identified during the medication pass observation. All</p>		

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F 332	<p>Continued From page 9</p> <p>The administration of the insulin more than 15 minutes before Resident #26 received a meal resulted in medication error #1.</p> <p>b. Medical record review revealed Resident #48 was admitted to the facility on 6/4/15 with diagnoses of Diabetes, Anxiety, Neuropathy, Insomnia, Hypothyroidism, Bronchitis, Restless Leg Syndrome, Hypertension, Peripheral Vascular Disease, and Constipation.</p> <p>A physician's order dated 12/11/15 documented, "...HUMALOG... INJECT 36 UNITS BEFORE LUNCH AND SUPPER... 11:30am... 4:30PM..."</p> <p>Observations in Resident #48's room on 1/11/16 at 4:15 PM, revealed LPN #3 administered Humalog 45 units SQ to Resident #48's abdomen. Resident #48 did not receive a meal until 1 hour and 8 minutes later, at 5:23 PM. The administration of the insulin more than 15 minutes before Resident #48 received a meal resulted in medication error #2.</p> <p>Interview with the Director of Nursing (DON) on 1/12/16 at 9:58 AM, in the admissions office, the DON was asked how soon after an injection of Humalog does she expect a resident to receive food. The DON stated, "30 minutes."</p> <p>2. Medical record review revealed Resident #47 was admitted to the facility on 5/13/14 with diagnoses of Generalized Muscle Weakness, Sacral Spina Bifida with Hydrocephalus, Chronic Respiratory Failure, Hypertension, Edema, Constipation, Anemia, seizures, and Chronic Obstructive Pulmonary Disorder.</p> <p>A physician's order dated 1/8/16 documented,</p>	F 332	<p>residents are potentially affected by similar deficient practices. Nurses were in-serviced regarding how and when to contact pharmacy for an unavailable medication that is due. Nurses also were in-serviced on the need to write an order to "Hold" an administration of an unavailable medication until available from pharmacy on 1-14-2016.</p> <p>No other medication errors were identified during the medication pass observation. Any resident receiving an enteral medication administration or feeding are potentially affected by similar deficient practices. The nursing staff was educated regarding enteral medication administration policies by 1-29-2016.</p> <p>3. Nursing administration will be triple checking change over monthly physician and NP orders. At the end of the month the</p>		

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F 332	<p>Continued From page 10</p> <p>"...MIRALAX POWDER... 9AM... GIVE 17GM [grams] INTO 8OZ [ounces] OF WATER BY MOUTH ONCE A DAY CONSTIPATION..."</p> <p>Observations on 1/12/16 at 8:40 AM, in Resident #47's room, LPN #1 failed to administer Miralax as ordered. This resulted in medication error #3.</p> <p>Interview with the DON on 1/12/16 at 2:30 PM, in the DON's office, the DON was asked if she would expect to run out of a resident's medicine. The DON stated, "It happens." The DON was asked if it should happen. The DON stated, "No, it should not, to answer your question."</p> <p>3. The facility's "Administering Medications through an Enteral Tube" policy documented, "...Administer medication by gravity flow..."</p> <p>Medical record review revealed Resident #50 was admitted to the facility on 9/9/14 with diagnoses of Multiple Sclerosis, Bipolar Disorder, Generalized Muscle Weakness, Neuropathy, Insomnia, Hypertension, Atherosclerotic Heart Disease, Heart Failure, Hemiplegia, Chronic Kidney Disease, Cerebrovascular Disease, Dysphagia, Suicidal Ideations, and Attention to Gastrostomy.</p> <p>The physician's orders dated 12/4/15 documented, "...GABAPENTIN 300MG [milligrams]... TAKE 1 CAPSULE via tube THREE TIMES DAILY... HYDRALAZINE 25MG... TAKE 1 TABLET EVERY 8 HOURS VIA TUBE... ACETAMINOPHEN 325MG... TAKE 2 TABLETS VIA TUBE EVERY 8 HOURS..."</p> <p>Observations outside Resident #50's room on 1/11/16 at 1:15 PM, revealed LPN #3 prepared medications for administration through a</p>	F 332	<p>Director of Nursing, Staff Development Coordinator, and Unit Manager will be ensuring that all medication orders are verified correctly and that the most current orders are in place. The Nurse Practitioner on 1/15/2016 began giving ALL telephone orders signed/dated and all physician orders signed/dated directly to a member of nursing administration. Medication administration (hands on in-servicing) will be conducted on a quarterly basis for all nursing staff for four months or until compliance is met. Offering a snack after the administration of insulin will now be added to the MAR for those residents' receiving insulin starting 1-15-2016 going forward. Weekly medication cart and medication storage room audits will be completed by the Director of Nursing on a weekly basis for three weeks and then monthly ongoing.</p>		

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F 332	Continued From page 11 gastrostomy tube. LPN #3 crushed 2 tablets of acetaminophen 325 mg and mixed with water, and crushed 1 tablet of hydralazine 25 mg mixed with water in another cup, and then opened 1 gabapentin capsule, and mixed it with water in another cup. LPN #3 then entered Resident #50's room, pulled up the acetaminophen/water mixture and pushed it into the gastrostomy tube using the syringe and plunger, leaving residual in the cup. LPN #3 administered hydralazine, leaving a large amount of residual in the cup. LPN #3 threw the cups containing the medication residual in the trash. The failure to administer all of the medications acetaminophen, gabapentin, and hydralazine resulted in medication errors #4, 5, and 6.  Interview with LPN #3 on 1/11/16 at 1:30 PM, in Resident #50's room, LPN #3 was asked whether there was any medication left in the discarded medication cups. LPN #3 confirmed there was, and stated, "I'm glad you saw that. I didn't."  Interview with the DON on 1/12/16 at 9:58 AM, in the admissions office, the DON was asked if it is acceptable to administer part of the medication, and throw away leftover residual water and medications. The DON stated, "No."	F 332	Nursing administration will continue to conduct quarterly, and as needed hands-on in servicing to all nurses. Nursing administration will continue to perform three monthly random medication pass observation for all nurses on all shifts starting 1-20-2016 going forward.  4. The Administrator or Director of Nurses will compile the audit/med pass results and present to the monthly Quality Assurance Performance Improvement Committee (Members include: Committee Chairperson – Administrator; Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) for 4 months for further recommendations and/or follow up as needed.		
F 332 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on review of the Geriatric medication				

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F 333	<p>Continued From page 12 handbook provided by the American Society of Consultant Pharmacists, policy review, medical record review, observation and interview, the facility failed to ensure 2 of 3 (Licensed Practical Nurses (LPN) #1 and 3) nurses administered medications free of significant medication errors. LPN #1 and 3 failed to administer insulin at the proper time frame related to food for Residents #26 and 48.</p> <p>The findings included:</p> <p>1. The facility's "Insulin Administration" policy documented, "...The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order... The four types of insulin and their characteristics are... Rapid-acting... Onset... 10- [to] 15 min [minutes]... Peak... 0.5-3 hrs [hours]..."</p> <p>The Geriatric medication handbook, eleventh edition, provided by the American Society of Consultant Pharmacists documented, "DIABETES: INJECTABLE MEDICATIONS... Humalog... Rapid-Acting Insulin Analog... ONSET... 15 min [minutes]... PEAK (Hours)... 0.5-1.5... TYPICAL ADMINISTRATION / COMMENTS... 15 minutes prior to meals..."</p> <p>a. Medical record review revealed Resident #26 was admitted to the facility on 4/8/14, with diagnoses of Chronic Congestive Heart Failure, Shortness of Breath, Generalized Muscle Weakness, Dysphagia, Diabetes, Alzheimer's Disease, and Depression.</p>	F 333	<p>1. Resident #26 and Resident #48 suffered no adverse outcomes related to insulin administration and subsequent medication errors. LPN #1 and LPN #3 were educated on properly identifying current physician orders pertaining to all medications that are to be administered on 1-12-2016</p> <p>2. No other medication errors were identified during the medication pass observation. All residents receiving insulin are potentially affected by similar deficient practices. All nurses were educated by the Director of Nurses or the Staff Development Coordinator for medication administration policies including medication pass competency test and observation. All current insulin medication orders were verified as current by the Unit Manager on 1-14-2016</p> <p>3. Nursing administration will be triple checking change over monthly physician and NP orders. At the end of month the Director</p>	1-29-2016	

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F 333	<p>Continued From page 13</p> <p>The physician's orders dated 12/11/15 documented, "...NOVOLOG... INJECT 12 UNITS SUB-Q [subcutaneous] TWICE DAILY... 11:30AM... 4:30PM..."</p> <p>Observations in Resident #26's room on 1/10/16 at 4:10 PM, revealed LPN #1 administered Humalog 20 units subcutaneous (SQ) to Resident #26's abdomen. Resident #26 did not receive a meal until 35 minutes later when her son brought her meal tray to her room on 1/10/16 at 4:45 PM.</p> <p>The administration of the insulin more than 15 minutes before Resident #26 received a meal resulted in a significant medication error.</p> <p>b. Medical record review revealed Resident #48 was admitted to the facility on 6/4/15 with diagnoses of Diabetes, Anxiety, Neuropathy, Insomnia, Hypothyroidism, Bronchitis, Restless Leg Syndrome, Hypertension, Peripheral Vascular Disease, and Constipation.</p> <p>A physician's order dated 12/11/15 documented, "...HUMALOG... INJECT 36 UNITS BEFORE LUNCH AND SUPPER... 11:30am... 4:30PM..."</p> <p>Observations in Resident #48's room on 1/11/16 at 4:15 PM, revealed LPN #3 administered Humalog 45 units SQ to Resident #48's abdomen. Resident #48 did not receive a meal until 1 hour and 8 minutes later, at 5:23 PM. The administration of the insulin more than 15 minutes before Resident #48 received a meal resulted in a significant medication error.</p> <p>Interview with the Director of Nursing (DON) on 1/12/16 at 9:58 AM, in the admissions office, the DON was asked how soon after an injection of</p>	F 333	<p>of Nursing, Staff Development Coordinator, and Unit Manager will be ensuring that all medication orders are verified correctly and that the most current orders are in place. The Nurse Practitioner on 1/15/2016 began giving ALL telephone orders signed/dated and all physician orders signed/dated directly to a member of nursing administration. Medication administration (hands on in-servicing) will be conducted on a quarterly basis for all nursing staff. Offering a snack after the administration of insulin will now be added to the MAR for those residents' receiving insulin starting 1-15-2016 going forward.</p> <p>4. The Administrator or Director of Nurses will compile the audit/med pass results and present to the monthly Quality Assurance Performance Improvement Committee (Members include: Committee Chairperson – Administrator; Director of Nursing; Medical Director; Dietary Director;</p>		

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F 333	Continued From page 14 Humalog does she expect a resident to receive food. The DON stated, "30 minutes."  Interview with the DON on 1/12/16 at 2:15 PM, in the DON's office, the DON was asked how much Humalog should Resident #48 have received. The DON stated, "The most current orders have not been signed, and that's why it's not in the chart." The DON confirmed the telephone orders dated 12/3/15 documented Resident #48 was to receive Humalog 45 units, and the more recent recertification orders signed by the nurse practitioner (NP) on 12/11/15 documented 36 units. The DON was asked why the more recent orders did not reflect the accurate dose of Humalog that was to be administered. The DON confirmed that the orders were not clear. The DON stated, "I'm not sure."	F 333	Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) for 4 months for further recommendations and/or follow up as needed.		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on policy review, observation, and interview, the facility failed to prepare and serve food under sanitary conditions as evidenced by 3 of 4 Dietary Workers (DW #1, 2, and 3) did not	F 371	1. No residents were identified to have suffered any adverse outcome due to the storage of germicidal wipes in the same drawer as food thickener. The nursing staff has been in-serviced on the proper storage of germicidal wipes and the need to properly note their expiration date on 1-16-2016 by the Director of Nursing or the Staff Development Coordinator. The dietary staff was in serviced on the proper way to wear their hair net on 1-12-2016 by the Dietary Manger. The dietary staff members were inspected for	1-29-2016	

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F 371	<p>Continued From page 15</p> <p>have their hair covered. This could potentially affect 45 residents receiving a tray from the kitchen of the 45 residents residing in the facility. The facility failed to ensure safe food storage as evidenced by bleach wipes being stored with food thickener in 1 of 3 (East hall medication cart) medication storage areas.</p> <p>The findings included:</p> <p>1. The facility's "Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices" policy documented that "...Hair nets... must be worn to keep hair from contacting exposed food..."</p> <p>a. Observations In the kitchen on 1/10/16 at 10:38 AM, revealed DW #1 did not have all her hair covered.</p> <p>b. Observations in the kitchen on 1/10/16 at 4:45 PM, revealed DWs #2 and 3 did not have all their hair covered.</p> <p>Interview with the Dietary Manager (DM) on 1/10/16 at 4:46 PM, in the kitchen, when the DM was asked if the dietary workers' hair was completely covered. The DM stated, "No."</p> <p>2. Observations in the east hall on 1/12/16 at 10:21 AM, revealed a canister of germicidal bleach wipes and two 8 ounces containers of food thickener stored in the same compartment in the bottom drawer of the east hall medication cart.</p> <p>Interview with Licensure Practical Nurse (LPN) #2 on 1/12/16 at 10:30 AM, in the east hall, LPN #2 was asked if bleach wipes should be stored with</p>	F 371	<p>compliance on 1-12-2016 with no discrepancies noted.</p> <p>2. All residents are potentially affected by the improper use of hair nets, and improperly stored expired germicidal wipes. The nursing staff was educated regarding the proper storage of germicidal wipes, and the need to label containers with the expiration date on 1-16-2016. The dietary staff was in serviced on how to properly ensue all their hair was contained in their hair nets on 1-12-16.</p> <p>3. Weekly medication cart and medication storage room audits will be completed by the Director of Nursing, Staff Development Coordinator or the Unit Manager on a weekly basis for three weeks. If no significant findings (expired meds, improperly stored meds/products etc.) after that period, the audits will continue on a monthly basis for four months.</p> <p>No expired, improperly stored, or medications nearing their expiration date were noted for</p>		

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F 371	Continued From page 16 the food thickener. LPN #2 stated, "No Ma'am, they shouldn't be."  Interview with the Director of Nursing (DON) on 1/12/16 at 1:25 PM, in the admission room, the DON was asked if bleach wipes should be stored with the food thickener in a medication cart. The DON stated, "Shouldn't be."	F 371	the dates of: January 15, 2016 and January 19, 2016. Clorox wipes are now clearly marked with their expiration date and stored in clear plastic bags to prevent leakage. Clorox wipes are now stored in a drawer in medication carts that is clearly labeled with the following laminated label: "This drawer is to be used for the purpose of Sanitation wipes. They are to be labeled with their expiration date and stored with no ingestible products and stored in an airtight clear plastic bag as of 1-20-2016. The Dietary Manager will conduct three random inspections a week to ensure compliance for four weeks and weekly for three months to ensure that hairnets are worn properly.		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH  The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.  The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.  This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation, and interview, the facility failed to ensure prescribed medications were available for		4. The Administrator or Director of Nurses will compile the audit results and present to the monthly Quality Assurance Performance Improvement Committee (Members include: Committee Chairperson – Administrator; Director of Nursing; Medical Director;		

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F 425	<p>Continued From page 17 administration as ordered to meet the needs of 1 of 7 (Resident #47) residents observed during medication administration.</p> <p>The findings included:</p> <p>The facility's "Medication and Treatment Orders" policy documented, "...Orders for medications and treatments will be consistent with principles of safe and effective order writing... Drugs and biologicals that are required to be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available..."</p> <p>Medical record review revealed Resident #47 was admitted to the facility on 5/13/14 with diagnoses of Sacral Spina Bifida with Hydrocephalus, Edema, Generalized Muscle Weakness, Anemia, Chronic Respiratory Failure, Hypertension, Constipation, Seizures, and Chronic Obstructive Pulmonary Disorder.</p> <p>A physician's order dated 1/8/16 documented, "...POLYETHYLENE GLYCOL 3350... MIRALAX POWDER... 9AM... GIVE 17GM [grams] INTO 8OZ [ounces] OF WATER BY MOUTH ONCE A DAY CONSTIPATION..."</p> <p>The Medication Administration Record for January 2016 documented, "...NURSE'S MEDICATION NOTES... 1/12/16... Miralax 17gm [grams]... Not available from pharm [pharmacy]... Will Notify/re-order [reorder]..."</p> <p>Observations on 1/12/16 at 8:40 AM, in Resident #47's room, LPN #1 failed to administer Miralax as ordered.</p>	F425=D	<p>Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) for 4 months for further recommendations and/or follow up as needed.</p> <p>1. Resident #47 suffered no adverse outcomes related to the miss of administration of Miralax. Resident #47 had received the dose of Miralax the day before the medication pass observation, according to the MAR (1-11-2016). LPN #1 was educated on properly identifying current physician orders pertaining to all medications that are to be administered. LPN #1 was also in-serviced on the need to write an order to "Hold" an administration of an unavailable</p>	1-29-2016	

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NAME OF PROVIDER OR SUPPLIER  <b>ARDMORE HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>25386 MAIN STREET ARDMORE, TN 38449</b>		
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F 425	Continued From page 18 Interview with the Director of Nursing (DON) on 1/12/16 at 2:30 PM, in the DON's office, the DON was asked if she would expect to run out of a resident's medicine. The DON stated, "It happens." The DON was asked if it should happen. The DON stated, "No, it should not, to answer your question."	F 425	medication until available from pharmacy on 1-26-2016.		
F 441 SS=D	<b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  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; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted		2. No other residents were identified during the medication pass observation audit. All residents are potentially affected by similar deficient practices. Nurses were in-serviced regarding how and when to contact pharmacy for an unavailable medication that is due. Nurses also were in-serviced on the need to write an order to "Hold" an administration of an unavailable medication until available from pharmacy on 1-14-2016.  3. Weekly medication cart and medication storage room audits will be completed by the Director of Nursing, Staff Development Coordinator, or the Unit Manager on a weekly basis for three weeks. If no significant findings (expired meds, improperly stored meds/products, products that are nearing completion etc.) After that period, the audits will be continued monthly going forward.  4. The Administrator or Director of Nurses will compile the audit results and present to the monthly Quality Assurance Performance		

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F 441	<p>Continued From page 19 professional practice.</p> <p>(c) Linens 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 observation and interview, the facility failed to ensure infection control practices were maintained to prevent the potential spread of infections as evidenced by an expired canister of germicidal bleach wipes stored in 1 of 3 (East hall medication cart) medication storage areas.</p> <p>The findings included:</p> <p>Observations in the east hall on 1/12/16 at 10:27 AM, revealed a canister of germicidal bleach wipes with an expiration date of 2/27/15 in the bottom drawer of the east hall medication cart.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 1/12/16 at 10:30 AM, in the east hall, LPN #2 was asked if the bleach wipes were expired. LPN #2 stated, "Yes." LPN #2 was asked should expired bleach wipes be on the medication cart. LPN #2 stated, "No ma'am they shouldn't."</p> <p>Interview with the Director of Nursing (DON) on 1/12/16 at 1:25 PM, in the admission office, the DON was asked if expired bleach wipes should be in the medication cart. The DON stated, "Shouldn't be."</p>	F441=D	<p>Improvement Committee (Members include: Committee Chairperson – Administrator; Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) ongoing for further recommendations and/or follow up as needed.</p> <ol style="list-style-type: none"> <li>No residents were identified to have suffered any adverse outcome due to the storage of germicidal wipes in the same drawer as food thickener. The nursing staff was in-serviced on the proper storage of germicidal wipes and the need to properly note their expiration date by 1-29-2016.</li> <li>All residents are potentially affected by expired and improperly stored germicidal</li> </ol>	1-29-2016	

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