

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

PRINTED: 10/30/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/24/2014
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NAME OF PROVIDER OR SUPPLIER ASHTON PLACE HEALTH & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3030 WALNUT GROVE RD MEMPHIS, TN 38111
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F 309 SS=E	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of facility's incident investigations, medical record review, observations and interviews, it was determined the facility failed to ensure staff followed physician's orders for medication administration, providing hand rolls and sending a resident to dialysis for 7 of 36 (Residents #7, 9, 11, 16, 30, 31 and 33) sampled residents.</p> <p>The findings included:</p> <p>1. Medical record review for Resident #7 documented an admission date of 8/25/08 with diagnoses of Lupus, Diabetes Mellitus, Chronic Kidney Disease, Anxiety, Chronic Pain, Debility, Hypertension, Psychosis, Depression, Bipolar Disease, History of Colon Cancer with Colostomy and Squamous Cell Cancer.</p> <p>Review of the physician's orders for January 2014 documented, "...LOVASTATIN 20 MG [milligrams]... TAKE 1 [one] TABLET BY MOUTH AT BEDTIME..." Review of the Medication Administration Record (MAR) for January 2014, revealed Lovastatin was not administered on 1/12/14 as ordered.</p>	F 309	<p>F309</p> <p>The statements made on this plan of Corrections are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state Regulations, Ashton Place Rehab and Care Center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p>F309 Residents #7, 9, & 11 The facility will assure that all residents receive medications as ordered by physician. Facility will continue to follow all policy & procedures on assuring all residents receive medications and assure all residents will receive 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.</p> <p>Residents # 7,9,11 had orders for medication and the Nurse failed to administer night time Medications. These residents were assessed on 1/13/14, by the former Director of Nursing & Assistant Director of Nursing and there were no negative findings. Family was notified of the following issue/s.</p>	10/25/14
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>[Signature]</i>	(X6) DATE 11/10/14
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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.

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F 309	Continued From page 1 2. Medical record review for Resident #9 documented an admission date of 4/9/13 with diagnoses of Reflux Disease, Myopia, Seizures, Anxiety, Aphasia, Dysphagia, Osteoporosis, Debility, Quadriplegia, History of Cerebral Vascular Accident and Hypertension. Review of the physician's orders for January 2014 documented, "...VALPROIC ACID 250 MG/5 ML [milligrams per milliliters].. GIVE 15MLS PER PEG [Percutaneous Endoscopy Gastrostomy Tube] EVERY 8 HOURS (SEIZURES)... SIMVASTATIN 5 MG TABLET... TAKE ONE TABLET VIA TUBE AT BEDTIME..." Review of the MAR for January 2014, revealed Valproic Acid and Simvastatin were not administered at bedtime on 1/12/14 as ordered. 3. Medical record review for Resident #11 documented an admission date of 6/20/12 with diagnoses of Weakness, Right Hemiplegia, Gout, Hypertension, History Prostate Cancer, Insomnia, Osteoarthritis, Osteoporosis and History of Gastrointestinal Bleeding. Review of the physician's orders for January 2014 documented, "...FENOFIBRATE 40 MG TABLET... TAKE 1 TABLET BY MOUTH AT BEDTIME... ATORVASTATIN 80 MG TABLET... TAKE 1 TABLET BY MOUTH AT BEDTIME... HYDRALAZINE HCL [hydrochloride] 25 MG... TAKE 1 TABLET BY MOUTH EVERY 8 HOURS... GABAPENTIN 300 MG CAPSULE... TAKE 1 CAPSULE BY MOUTH EVERY 8 HOURS... METOCLOPRAMIDE 5 MG... TAKE ONE TABLET BY MOUTH BEFORE MEALS AND AT BEDTIME... TRAZODONE 50 MG... TAKE 1 TABLET BY MOUTH AT BEDTIME..." Review of	F 309	Former Director of Nursing interviewed the nurse that failed to provided medications. A investigation was completed and the Nurse was terminated for failure to follow policy & procedures. The Nurse was reported to state nursing board. On 1/14/2014 the Previous Director of Nursing & Assltant Director of Nursing began in-servicing all nursing staff on following policy & procedures and assuring all physician orders were being followed. On 10/24/14 current Director of Nursing & Assistant Director of Nursing and the Staff Development Coordinator started in-servicing all Nursing staff on our current Policy & Procedures, and on following physician orders. Nursing staff was also in-serviced on the protocol to follow when a nurse doesn't show up or fails to be timely to show up for their assigned hall. Starting 11/07/14, and for 12 weeks, the DON/ADON/Designee will periodically audit 6 resident orders each week to assure all orders are followed and all audits will be discussed at the weekly meeting (on Fridays) with the interdisciplinary team to discuss all progress/findings. All negative findings will be discussed at the Monthly Quality Assurance Meeting and will be followed for 3- months.	11/15/14	

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F 309	<p>Continued From page 2</p> <p>the MAR for January 2014, revealed that none of the bedtime medications were given on 1/12/14 as ordered.</p> <p>Review of the facility schedule for 1/12/14, documented that Nurse #3 was working the evening shift on 1/12/14. During a telephone interview with Nurse #3 on 10/23/14 at 11:30 AM, Nurse #3 stated that she had given the medications, but "...didn't sign them out..."</p> <p>Review of a facility investigation that the resident was not given his bedtime medications on 1/12/14, documented Nurse #3 admitted that she had not given any medications (including Resident #7 and 9) on the evening of 1/12/14.</p> <p>4. Medical record review for Resident #16 documented an admission date of 11/22/13 with diagnoses of Cerebrovascular Disease, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease and Osteomyelitis. Review of the physician's orders dated 12/17/13 documented, "Hand rolls RE [regarding]: Contractures of Hands."</p> <p>Observations in Resident #16's room on 10/15/14 at 10:45 AM and 12:15 PM; on 10/16/14 at 11:50 AM and 2:05 PM; on 10/17/14 at 10:30 AM; on 10/20/14 at 10:00 AM; on 10/21/14 at 10:10 AM and on 10/22/14 at 11:20 AM and 2:00 PM, revealed no hand rolls in Resident #16's hands.</p> <p>During an interview in Resident #16's room on 10/22/14 at 2:05 PM, Nurses #14 confirmed there were no hand rolls in Resident #16's hands.</p> <p>5. Closed medical record review for Resident #30 documented an admission date of 2/11/14 with diagnoses of Hip Replacement, Weakness,</p>	F 309	<p>F 309 Resident # 16 All residents with physician orders for hand-rolls were identified by the Director of Nursing & the Assistant Director of Nursing.</p> <p>All residents with Hand Rolls (orders) were placed on an audit form and the Restorative Aides will audit daily (each shift) All residents with orders for hand-rolls will be placed on the MARS.</p> <p>To assure hand rolls are in place according to each physician order RA staff will audit daily for 12 weeks and a report will be given to the Director of Nursing each Friday.</p>	11/15/14	

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F 309	Continued From page 4 Review of a facility investigation that Resident #30 had not received his/her pain medications on 5/15/14, documented Nurse #4 was terminated after a drug screen revealed she tested positive for Oxycodone and Marijuana. Attempts to contact Nurse #4 by telephone were unsuccessful. 6. Closed medical record review for Resident #31 documented an admission date of 7/17/14 with diagnoses of History of a Fall with a Subdural Hematoma, Hypertension, Congestive Heart Failure, Anemia, Cardiomegaly, Seizures, Alzheimer's Disease and End Stage Renal Disease with Dialysis. Review of the nurse's notes dated 9/24/14 (Wednesday) at 7:00 PM, documented "...Phone called received from dialysis res. [resident] was sent to [named hospital] R/T [related to] status [symbol for change]..." A nurse's note dated 9/29/14 (Monday) at 8:00 PM, documented "...Readmit... Arrived via ambulance... Dialysis ongoing M [Monday] -W [Wednesday] -F [Friday]... orders noted..." Review of the nurses' notes and the Dialysis communication records revealed there was no documentation the resident was sent to dialysis on Wednesday, 10/1/14, or Friday, 10/3/14. There was a dialysis communication record dated 10/4/14, Saturday, that the resident had been sent for dialysis. During an interview in the conference room on 10/21/14 at 9:00 AM, the Assistant Director of Nursing stated, "...called dialysis... she didn't go those two days..." During an interview in the conference room on	F 309	An assessment was completed on the resident (on 5/16/14) by the DON and there were no negative findings. Current Director of Nursing & Administrator started in-servicing (11/3/14) on our facilities new Policy & Procedures on Diversion of Medications. Facility will continue to In-service all staff until all staff is educated on the new policy & procedures. In-services will be completed by 11/15/14. Human Resources will complete 5 random drug screenings (on nurses) each month for 3-months. All staff with negative screenings will be investigated and brought to the Interdisciplinary team for corrective action. Director of Nursing/ Assistant Director/ or designee will Visit with oriented residents (2 per week for 12 weeks) to assure all residents are receiving their ordered medications. All negative findings will be reported to the monthly Quality Assurance Committee for 3-months. Resident the # 31 Resident returned from the Hospital on 9/29/14 and missed her dialysis on 10/1/14 & 10/03/14. She did receive dialysis on 10/4/14.	11/06/14	

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F 309	<p>Continued From page 5</p> <p>10/24/14 at 8:45 AM, the Director of Nursing (DON) was asked why the resident was not sent out to dialysis. The DON stated, "I know she went to the hospital. Dialysis in the hospital on Monday [9/29/14]... didn't go on Wednesday [10/1/14]... don't know why... didn't find anything documented. I looked, too. Found out late Friday [10/3/14] she hadn't gone... daughter called [named the administrator]... that's when we found out... made arrangements for her to go on Saturday [10/4/14]..." The DON further stated the resident did not have any problems related to the missed treatments.</p> <p>7. Closed medical record review for Resident #33 documented an admission date of 2/27/14 with diagnoses of Multiple Myeloma Relapse, Adult Failure to Thrive, Weakness, Hypertension and Reflux Disease.</p> <p>Review of the May 2014 physician's orders documented, "...MULTIVIT W/ MINERALS... TAKE 1 TABLET BY MOUTH ONCE DAILY... BISACODYL EC [enteric coated] 5MG... TAKE 1 TABLET BY MOUTH ONCE DAILY... METOPROLOL TARTRATE 25 MG... TAKE ONE TABLET BY MOUTH EVERY 12 HOURS... Megestrol... 400mg/10ml... take 2tsp [teaspoons] BID [twice daily]..." Review of the May 2014 MAR revealed Resident #33 did not receive her morning medications on 5/15/14.</p> <p>Review of a facility investigation that Resident #33 had not received this/her pain medications on 5/15/14, documented Nurse #4 was terminated after a drug screen revealed she tested positive for Oxycodone and Marijuana. Attempts to contact Nurse #4 by telephone were unsuccessful.</p>	F 309	<p>On 10/03/14 at approx.. 9:00pm the Administrator discovered that resident didn't receive her dialysis. Administrator called the dialysis unit and set up dialysis for the next morning (10/04/14)</p> <p>On 10/03/04 the Nurse completed an assessment on resident to assure all vitals were ok and she was ok. There were no negative findings.</p> <p>On 10/06/14, the ADON started education with all nursing staff on the importance of assuring all residents receive dialysis as ordered by the physician. 100% of all Nursing staff will receive this education by (11/15/2014)</p> <p>DON & ADON meet with all Unit (on 10/24/14) and set up a binders on each wing that had all dialysis residents and the days they go to dialysis. All residents with dialysis also had their scheduled days placed on the MARS.</p> <p>Our social department was also in-serviced (on 10/24/14) on the importance of assuring the transport service (picking up dialysis residents) were notified of all new admissions re-admits with scheduled days for dialysis. All new staff will receive this training in orientation.</p> <p>ADON/DON will monitor all dialysis residents (going to dialysis) for 12 weeks. DON/ADON will monitor weekly to assure each dialysis binders is updated with each new admission. All audits will be discussed in the weekly interdisciplinary team</p>		

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			<p>And all findings will be shared in the monthly Quality Assurance meeting for the next 3-months.</p> <p>Resident # 33</p> <p>F 309</p> <p>Resident # 33 didn't receive her medications as ordered (5/15/14) the previous Director of Nursing & Previous Administrator completed a self-report to the state on the resident not receiving her medications. A complete investigation was completed on the nurse.</p> <p>Drug test was completed on this identified Nurse and this screening showed Oxycodone and Marijuana. Facility terminated the nurse.</p> <p>An assessment was completed on the resident (on 5/16/14) by the DON and there were no negative findings</p> <p>Current Director of Nursing & Administrator started in-servicing (11/3/14) on our facilities new Policy & Procedures on Diversion of Medications. Facility will continue to In-service all staff until all staff is educated on the new policy & procedures. In-services will be completed by 11/15/14.</p>	<p>10/25/14</p>
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