

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 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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(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
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F 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted along with abbreviated surveys from October 14, 2014 through October 24, 2014. Complaints #TN00033074, #TN00033076, #TN00033060, #TN00033068, #TN00033105, #TN00033264, #TN00033395, #TN00033441, #TN00034294, #TN00033756, #TN00033757, #TN00033960, #TN00033961, #TN00033962, #TN00034099, #TN00034101, #TN00034106, #TN00034220, #TN00034396, #TN00034602, #TN00034800 and #TN00034816 were investigated with the recertification survey. There were no deficiencies cited for these twenty-two complaints.</p> <p>Complaints #TN00033207, #TN00033897 and #TN00034857 were also investigated with the recertification survey with deficiencies cited at F309 E in relation to the allegations on the complaints and during the recertification survey completed on 10/24/14.</p>	F 000	<p>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.</p> <p>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.</p>	
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,</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>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 11/10/14

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 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. The findings included: 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. 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. 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	F 309	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. 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. 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 & Assistant 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.	11/06/14	

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F 309	<p>Continued From page 2</p> <p>the MAR for January 2014, revealed Valproic Acid and Simvastatin were not administered at bedtime on 1/12/14 as ordered.</p> <p>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.</p> <p>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 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>	F 309	<p>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.</p>	11/06/14	

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F 309	Continued From page 3 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." 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. 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. 5. Closed medical record review for Resident #30 documented an admission date of 2/11/14 with diagnoses of Hip Replacement, Weakness, Hypertension, Hypothyroid, Hyperlipidemia, Diabetes Mellitus, History of Gastric Bypass, Sarcoidosis and History of Deep Vein Thrombosis. Review of the May 2014 physician's orders documented, "...PROVIDE GOLD REGULAR... GIVE 30MLS BY MOUTH DAILY... POLYETHYLENE GLYCOL... MIX 17GM [grams]... IN 8 OZ [ounces] OF LIQUID AND TAKE BY MOUTH DAILY... MAGNESIUM OXIDE 400 MG... TAKE ONE TABLET BY MOUTH WITH SUPPER... CITALOPRAM... 20 MG... TAKE 1 TABLET BY MOUTH ONCE DAILY... MULTIVIT [multivitamin] W/ [with] MINERALS...	F 309	F 309 Resident # 16 All residents with physician orders for hand-rolls were identified by the Director of Nursing & the Assistan Director of Nursing. 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. 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. Staff Development Coordinator will also audit each resident with orders for hand rolls. This will be done weekly for 12 weeks, with a weekly report given to the DON each Friday. In- service with all Nursing Staff began on 10/24/14 and will continue until all staff is in-serviced on following all orders (hand rolls) This in-service also focused on the facilities Policy on assuring each resident continues to receive treatment according to their physician orders. All staff will be in-serviced by 11/15/14. These audits will be discussed each friday with the interdisciplinary team. All negative findings will be reported to the monthly Quality Assurance meeting for 3 months.	11/06/14	

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F 309	<p>Continued From page 4</p> <p>TAKE 1 TABLET BY MOUTH ONCE DAILY... LEVOTHYROXINE 100 MCG [micrograms]... TAKE 2 TABLETS EVERY MORNING... OXYCONTIN 10 MG... TAKE 2 TABLETS BY MOUTH EVERY 12 HOURS... DOCUSATE SOD [sodium] 100MG... TAKE 1 CAPSULE BY MOUTH EVERY 12 HOURS... HYDROCODON-APAP [Hydrocodone with Acetaminophen] 5-325... TAKE ONE TABLET BY MOUTH EVERY 6 HOURS AS NEEDED... METOCLOPRAMIDE 5MG... TAKE 1 TABLET BY MOUTH FOUR TIMES DAILY... HYDROCORTISONE 1% [one percent] CREAM... APPLY TOPICALLY WITH A THIN LAYER DAILY UNTIL RESOLVED TO BLE [bilateral lower extremities]..." Review of the May 2014 MAR revealed the resident did not receive her day time medications on 5/15/14.</p> <p>Review of a nurse's note dated 5/15/14 documented, "...Pain assessment completed at this time. Resident states she did not get her pain meds... No acute adverse effects noted from omission error. No new orders rec'd [received]..."</p> <p>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.</p> <p>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</p>	F 309	<p>F 309</p> <p>Residents # 30 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>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.</p>	11/06/14	

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F 309	<p>Continued From page 5 Disease with Dialysis.</p> <p>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.</p> <p>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..."</p> <p>During an interview in the conference room on 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</p>	F 309	<p>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.</p> <p>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.</p> <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>	11/15/14	

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F 309	<p>Continued From page 6</p> <p>#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>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> <p>And all findings will be shared in the monthly Quality Assurance meeting for the next 3-months.</p>	11/15/14
F 322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that -</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate</p>	F 322	<p>F-322</p> <p>Resident # 9</p> <p>The facility will ensure that a resident Who is fed by a gastrostomy (PEG) Tube receives the appropriate treatment And services to prevent aspiration Pneumonia, diarrhea, vomiting, Dehydration, metabolic abnormalities And nasal-pharyngeal ulcers and to Restore, if possible, normal eating skills.</p>	11/15/14

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F 322	<p>Continued From page 7 treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure Percutaneous Endoscopy Gastrostomy (PEG) tube care was provided according to the facility policy and physician's orders for 1 of 1 (Resident #9) sampled resident observed during medication administration.</p> <p>The findings included: Review of the facility's "Administering Medications through an Enteral Tube" policy, documented, "...21. When correct tube placement and acceptable GRV [gastric residual volume] have been verified, flush tubing with 15- [to] 30 ml [milliliters] warm sterile water (or prescribed amount)... 23. Dilute the crushed or split medication with 15-30 ml sterile water (or prescribed amount)... 26. If administering more than one medication, flush with 5 ml (or prescribed amount) warm sterile water between medications. 27. When the last medication begins to drain from the tubing, flush the tubing with 15-30 ml of warm sterile water (or prescribed amount)..."</p>	F 322	<p>Resident # 9=physician was notified That the tube feeding for this resident Wasn't administered per policy. Nurse failed To complete the flush with 5 ml of warm water Between medications and failed to flush With 30 ml of water before and after The medications were given.</p> <p>On 10/24/14, when the DON discovered The nurse failed to follow this policy, the Nurse providing the tube feeding (medication Administration) was provided a one on one Training session on our policy & procedures.</p> <p>On 10/24/14 the DON & ADON completed an assessment on The resident and found no adverse effects.</p> <p>On 10/24/14,(and ongoing for 12 weeks) a weekly medication administration Observation audit will be completed by the DON/ADON/Designee on 2 residents with PEG's. All weekly audit results will be brought To the weekly interdisciplinary team each Friday.</p> <p>Starting on 10/24/14 and ongoing All Nursing Staff will be in-serviced On appropriate technique for Administering medications through An enteral tube, flushing before, during and After medications .Also in-serviced staff to assure that all medications/complete dose is given. Assure that all residue is flushed. (by 11/15/14, all Nursing staff will be in-serviced).</p> <p>DON/ADON, or designee will report a Summary of these weekly findings to The monthly Quality Assurance meetings. This will continue for the next 3-months.</p>	11/15/14
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F 322	<p>Continued From page 8</p> <p>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, Hypertension, History of Cerebral Vascular Accident and a PEG Tube.</p> <p>Review of the most recent recertification orders dated 9/4/14, documented "...FLUSH [PEG] TUBE W [with] / 30ml BEFORE & [and] AFTER EACH MED [medication] PASS... CLOPIDOGREL, 75 MG [milligrams] TABLET TAKE 1 TABLET... ONCE DAILY... FOLIC ACID 1 MG TABLET... TAKE 1 TABLET... ONCE DAILY... CLONIDINE 0.1MG... TAKE 1 TABLET... TWICE DAILY..."</p> <p>Observations in Resident #9's room on 10/16/14 at 9:00 AM, Nurse #1 crushed the medications and mixed each with 5 ml of tap water. Nurse #1 administered each medication separately, and flushed with 5 ml of tap water between each medication. After the last medication was administered, she flushed the PEG tube with 10 ml of tap water. Nurse #1 did not use sterile water according to the facility policy, and she did not flush the PEG tube with 30 ml of water before and after administering the medications.</p> <p>During an interview in Resident #9's room on 10/16/14 at 9:00 AM, Nurse #1 stated that she mixed each medication with 5 ml of water, and that she was concerned that she would go "over his water" needs. At 9:20 AM, she stated she had flushed the PEG tube with 10 ml of water after the medications were given.</p>	F 322			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332			

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

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F 332	Continued From page 9 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 medication guide for the long term care nurse, policy review, medical record review, observation and interview, it was determined the facility failed to ensure 2 of 6 (Nurses #1 and 2) nurses administered medications with a medication error of less than five percent (%). There were 4 medication errors out of 27 opportunities for error, which resulted in a medication error rate of 14.81%. The findings included: 1. Review of the medication guide for the long term care nurse, fourth edition, page 69, documented, "...Administer prescribed medication... Rinse medication cup with water or prescribed diluents and administer to assure delivery of the completed dose..." Review of the facility's medication administration through an enteral tube policy, documented, "...flush tubing with 15- [to] 30 ml [milliliters] warm sterile water (or prescribed amount)... 23. Dilute the crushed or split medication with 15-30 ml sterile water (or prescribed amount)... 27. When the last medication begins to drain from the tubing, flush the tubing with 15 - 30 ml of warm sterile water (or prescribed amount)..." Medical record review for Resident #9 documented an admission date of 4/9/13 with	F 332	Resident # 9 & # 21 The facility will ensure that a resident Who is fed by a gastrostomy (PEG) Tube receives the appropriate treatment And services to prevent aspiration Pneumonia, diarrhea, vomiting, Dehydration, metabolic abnormalities And nasal-pharyngeal ulcers and to Restore, if possible, normal eating skills. Resident # 9=physician was notified That the tube feeding for this resident Wasn't administered per policy. Nurse failed To complete the flush with 5 ml of warm water Between medications and failed to flush With 30 ml of water before and after The medications were given. On 10/24/14, when the DON discovered The nurse failed to follow this policy, the Nurse providing the tube feeding (medication Administration) was provided a one on one Training session on our policy & procedures. On 10/24/14 the DON & ADON completed an assessment on The resident and found no adverse effects. On 10/24/14,(and ongoing for 12 weeks) a weekly medication administration Observation audit will be completed by the DON/ ADON/Designee on 2 residents with PEG's. All weekly audit results will be brought To the weekly interdisciplinary team each Friday.	11/15/14	

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F 332	<p>Continued From page 10</p> <p>diagnoses of Reflux Disease, Myopia, Seizures, Anxiety, Aphasia, Dysphagia, Osteoporosis, Debility, Quadriplegia, Hypertension, History of Cerebral Vascular Accident, and a PEG Tube. Review of the recertification orders signed 9/4/14, documented "...FLUSH [PEG] TUBE W [with]/30ml BEFORE & [and] AFTER EACH MED [medication] PASS...CLOPIDOGREL 75 MG [milligrams] TABLET TAKE 1 TABLET...ONCE DAILY...FOLIC ACID 1 MG TABLET...TAKE 1 TABLET...ONCE DAILY...CLONIDINE 0.1MG...TAKE 1 TABLET...TWICE DAILY..."</p> <p>Observations in Resident #9's room on 10/16/14 AT 9:00 AM, Nurse #1 mixed crushed medications with 5 ml of tap water. Nurse #1 administered each medication separately, and flushed with 5 ml of tap water between each medication. Nurse #1 did not rinse the medication cups to ensure the complete dose of medication was administered. There was medication residual left in each of the medication cups after Nurse #1 gave the medications. After the last medication was administered, Nurse #1 flushed the PEG tube with 10 ml of tap water. Nurse #1 did not administer the entire dose of Clopidogrel, Folic Acid or Clonidine which resulted in medication errors #1, 2 and 3.</p> <p>During an interview in Resident #9's room on 10/16/14 at 9:20 AM, Nurse #1 was asked how she knew the resident received all of his medications with powder residue left in all three the cups. Nurse #1 stated, "I do the best I can. It's just hard when you crush them." Nurse #1 stated she mixed each medication with 5 ml of water, and that she was concerned that she would go "over his water" needs.</p>	F 332	<p>Starting on 10/24/14 and ongoing All Nursing Staff will be in-serviced On appropriate technique for Administering medications through An enteral tube, flushing before, during and After medications .Also in-serviced staff to assure that all medications/complete dose is given Assure that all residue is flushed. (by 11/15/14, all Nursing staff will be in-serviced).</p> <p>On 10/16/14, Resident # 21 received a fingerstick blood stick sugar of 268. surveyor ask nurse if Resident received insulin, and Nurse said no ma'am she only gets insulin if Blood Sugar is over 300. after surveyor left, the nurse reviewed the order and found that resident (according to the order) should have received 6 units. The nurse immediately gave the 6 units and observed resident to assure they were ok.</p> <p>On 10/24/14, DON/ADON reviewed all residents orders for insulin. These orders were shared with all nursing staff and all Nursing staff was in-serviced on validating & verifying all orders upon checking all residents blood sugar.</p> <p>Starting on 11/6/14, DON/ADON/Designee will audit 2 residents weekly (orders with sliding scale insulin) for 4 weeks and then once a week for next 8 weeks.</p>	11/15/14	

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F 332	Continued From page 11 2. Medical record review for Resident #21 documented an admission date of 3/13/14 with diagnoses of Weakness, Hypertension, Aphasia, Right Hemiplegia, Occluded Superior Vena Cava, History of Breast Cancer, History of Cerebral Vascular Accident and Diabetes Mellitus. Review of the physician's recertification orders signed 10/6/14 documented, "...HUMULIN R [regular insulin]... SS [sliding scale] BEFORE MEALS AND AT BEDTIME... 251- [to] 300 = [amount of insulin to be administered] 6UNITS..." During observations and an interview in Resident #21's room on 10/16/14 at 11:10 AM, Nurse #2 obtained a fingerstick blood sugar of 268. Nurse #2 was asked if Resident #21 would receive any insulin coverage for that blood sugar. Nurse #2 stated, "No ma'am, she doesn't get anything unless it's [blood sugar] over 300." The failure to administer 6 units of Humulin R insulin to Resident #21 according to her sliding scale order resulted in medication error #4.	F 332	All audits will be brought to the Weekly (each Friday) team meeting for discussion and Tracking. DON/ADON, or designee will report a summary of these weekly findings to the monthly Quality Assurance meetings. This will continue for the next 3-months.	11/15/14	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, it was determined the facility failed to ensure 1 of 6 (Nurses #2) nurses administered medications without a significant medication error. The findings included:	F 333	Resident # 9 & # 21 The facility will ensure that a resident Who is fed by a gastrostomy (PEG) Tube receives the appropriate treatment And services to prevent aspiration Pneumonia, diarrhea, vomiting, Dehydration, metabolic abnormalities And nasal-pharyngeal ulcers and to Restore, if possible, normal eating skills. Resident # 9=physician was notified That the tube feeding for this resident Wasn't administered per policy. Nurse failed To complete the flush with 5 ml of warm water Between medications and failed to flush With 30 ml of water before and after The medications were given.	11/15/14	

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F 333	Continued From page 12 Medical record review for Resident #21 documented an admission date of 3/13/14 with diagnoses of Weakness, Hypertension, Aphasia, Right Hemiplegia, Occluded Superior Vena Cava, History of Breast Cancer, History of Cerebral Vascular Accident and Diabetes Mellitus. Review of the physician's recertification orders signed 10/6/14 documented, "...HUMULIN R [regular insulin]... SS [sliding scale] BEFORE MEALS AND AT BEDTIME... 251- [to] 300 = [amount of insulin to be administered] 6UNITS..." During observations and an interview in Resident #21's room on 10/16/14 at 11:10 AM, Nurse #2 obtained a fingerstick blood sugar of 268. Nurse #2 was asked if Resident #21 would receive any insulin coverage for that blood sugar. Nurse #2 stated, "No ma'am, she doesn't get anything unless it's [blood sugar] over 300." The failure to administer 6 units of Humulin R insulin to Resident #21 according to her sliding scale order resulted in a significant medication error.	F 333	On 10/16/14, Resident # 21 received a fingerstick blood stick sugar of 268. surveyor ask nurse if Resident received insulin, and Nurse said no ma'am she only gets insulin if Blood Sugar is over 300. after surveyor left, the nurse reviewed the order and found that resident (according to the order) should have received 6 units. The nurse immediately gave the 6 units and observed resident to assure they were ok. On 10/24/14, DON/ADON reviewed all residents orders for insulin. These orders were shared with all nursing staff and all Nursing staff was in-serviced on validating & verifying all orders upon checking all residents blood sugar. Starting on 11/6/14, DON/ADON/Designee will audit 2 residents weekly (orders with sliding scale insulin) for 4 weeks and then once a week for next 8 weeks. All audits will be brought to the Weekly (each Friday) team meeting for discussion and Tracking. DON/ADON, or designee will report a summary of these weekly findings to the monthly Quality Assurance meetings. This will continue for the next 3-months.	11/15/14	