

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

PRINTED: 02/22/2016
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 02/17/2016
NAME OF PROVIDER OR SUPPLIER ASHTON PLACE HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3030 WALNUT GROVE RD MEMPHIS, TN 38111	
(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 309 SS=D	<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: Intakes: TN00037993</p> <p>Based on policy review, medical record review, and Interview, the facility failed to follow physician medication orders for 2 of 5 (Residents #2 and 4) sampled residents with Infections.</p> <p>The findings included:</p> <p>1. Review of the facility's "Administering Medications" policy documented, "...Medications shall be administered in a safe and timely manner, and as prescribed... If a medication is ordered and not available from the pharmacy, the ordering physician or Nurse Practitioner/Physician Assistant should be notified for an alternative order until medication is available..."</p> <p>2. Medical record review for Resident #2 documented an admission date of 7/17/14 with diagnoses of Anemia, Peripheral Vascular Disease, Vascular Dementia, Diabetes Mellitus, Hypertension, and Rheumatoid Arthritis.</p> <p>Nurses notes dated 2/3/16 documented, "wheezing noted. n.o. [new order] CXR [chest</p>	F 309	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Ashton Place Health and Rehabilitation does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>F309</p> <p>How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Physician was notified on 02/17/16 that resident #2's medications were not started until 2/5/16 and a medication error report was completed on 02/17/16. Physician was notified on 02/17/16 that resident # 4's medications were not started until 2/4/16 and 2/10/16 respectively and a medication error report was completed on 02/17/16.</p>	03/16/16

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

TITLE

(X6) DATE

Shirley Boyd, Administrator

03/02/2016

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	<p>Continued From page 1 x-ray]. Duoneb q [every] 6 hrs [hours] x [times] 5 days..."</p> <p>A physician's telephone order dated 2/3/16 at 8:35 PM documented, "...Start Z-Pac as directed... Prednisone 20 mg [milligrams] po [by mouth] q day x 5 days..."</p> <p>The Medication Administration Record (MAR) dated 2/1/16 through 2/29/16 documented, "...Prednisone 20 mg po q day x 5 days 9 A [9:00 AM]... NURSE'S MEDICATION NOTES 9 A Prednisone - on order from pharmacy... Azithromycin [Z Pac] 250 mg 2 tablets Day 1 9 AM...[nurses initials for administration on 2/5/16]..." The first doses of Prednisone and the Z Pac were not administered until 2/5/16.</p> <p>A nurses note dated 2/5/16 at 11:00 AM documented, "On Azithromycin for bronchitis. Day 1 of 5, no adverse reaction noted, will continue to monitor..."</p> <p>Interview with Registered Nurse (RN) #1, on 2/17/16 at 3:00 PM, in the conference room, RN #1 was asked what the procedure was for obtaining and administering new medications. RN #1 stated, "When we get a new order we fax it to the pharmacy. If the pharmacy does not bring it we get what we can from PIXIS [Medication Dispensing System]. If not in the PIXIS we can call the pharmacy and get it brought to the facility stat [immediately] even after hours. They have an on-call person. New orders should start the same day."</p> <p>2. Medical record review for Resident #4 documented an admission date of 11/18/14 and readmission date of 1/13/16 with diagnoses of</p>	F 309	<p>How the facility will identify other Residents having the potential to be affected by the same deficient practice.</p> <p>All residents have the potential to be affected.</p> <p>What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>100% of licensed nursing staff will be in-serviced by 3-16-16 on facility's Administering Medications policy. This policy states if a medication is ordered and not available from the pharmacy or included in the back up medication dispensing system, the physician is to be notified for an alternative order until medication is available. An antibiotic monitoring log will be utilized 3x/week x 4 weeks, then weekly x 4 weeks, then monthly x 2 months to ensure antibiotics are delivered and started in a timely manner.</p> <p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p>	03/16/16

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F 309	<p>Continued From page 2</p> <p>Diabetes Mellitus, Right Below Knee Amputation, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, and Hypertension.</p> <p>A physician's telephone order dated 2/1/16 documented, "...Stool for C DIFF [Clostridium Difficile] testing..." A physician's telephone order dated 2/3/16 documented, "...Flagyl 500 mg PO q 8 h [hours] x 14 days..." and 2/9/16, "...Vanco [Vancomycin] 125 mg q 6 h x 10 days..."</p> <p>The MAR dated February 2016 documented the first dose of Flagyl was not administered until 2/4/16 and the first dose of Vancomycin was not administered until 2/10/16.</p> <p>Interview with the Director of Nurses (DON), on 2/17/16 at 5:50 PM, in the conference room, the DON was asked why the Flagyl and Vancomycin were not administered until the day after they were ordered. The DON stated, "I checked the skilled [nurses notes] in the computerized charting but can't find anything. I don't know the time they were ordered. I don't know why the next day [when medications were administered]. The pharmacy was called, just not delivered."</p>	F 309	<p>The Administrator or Director of Nursing will present the audit results 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 for further recommendations and/or follow up as needed.</p>	03/16/16
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