

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

RECEIVED

JAN 04 OMB NO. 0938-0391 FORM APPROVED

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 12/10/2015
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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 000	INITIAL COMMENTS Complaints TN00037806 and TN0003779 were investigated during the recertification survey conducted from 12/7/15 through 12/10/15. Complaint #TN00037806 was substantiated with deficiencies cited in F164, F166, F250, F280 and F309. Complaint TN0003779 was substantiated with deficiencies cited in F166, F224, F225, F250 and F282.	F 000	"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."	
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment	F 164		

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

George Murchow

TITLE

CEO-Administrator

(X6) DATE

12-30-15

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 164	<p>Continued From page 1 contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, the facility failed to ensure privacy was maintained for 4 of 51 (#38, 146, 158, and 255) residents included in the stage 2 review.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. The facility's "Privacy" policy documented, "...You have the right to personal privacy, including privacy in accommodations, medical treatment... personal care, visits..." 2. Medical record review revealed Resident #38 was admitted to the facility on 8/28/14 with diagnoses of Hypertension, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Peripheral Vascular Disease, Hypothyroidism, and Chronic Kidney Disease. <p>Interview with Resident #38 on 12/8/15 at 8:28 AM, in Resident #38's room, Resident #38 was asked do staff provide you privacy when they work with you, changing your clothes or providing treatment. Resident #38 stated, "No, it only takes one person to help me and sometimes there will be 2 or 3 people come in. They don't always pull the curtain."</p> <ol style="list-style-type: none"> 3. Medical record review revealed Resident #146 was admitted to the facility on 6/5/12 with diagnoses of Osteoarthritis, Chronic Pain, Borderline Personality Disorder, Dementia with Behaviors, Mood Disorder, Personality Disorder, 	F 164	<p><u>F164</u></p> <p>How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Staff are being in-serviced on the Quality of Life – Dignity Policy to ensure that all residents, including resident # 38, #146, and #158 are having their curtain pulled during personal care and staff are identifying themselves when knocking, asking permission to enter, and awaiting on permission prior to entering. Resident # 257 expired on 12-8-15.</p>	1-10-2016	

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F 164	<p>Continued From page 2</p> <p>Hypertension, Peripheral Vascular Disease, Chronic Obstructive Pulmonary Disease, Reflux Disease, Diabetes Mellitus, and Polyneuropathy.</p> <p>Interview with Resident #146 on 12/7/15 at 3:12 PM, in Resident #145's room, Resident #146 was asked do the staff provide you privacy when they work with you. Resident #146 stated, "I have to tell people to pull the curtain or close the door when they are working with me."</p> <p>4. Medical record review revealed Resident #158 was admitted to the facility on 8/30/13 with diagnosis of Hepatic Failure, Alcoholic Cirrhosis of Liver without Ascites, Carrier of Viral Hepatitis C, Vitamin D Deficiency, Hypokalemia, Vascular Dementia, Mood Disorder, Major Depressive Order, Insomnia, Chronic Pain Syndrome, Hypertension, Chronic Kidney Disease, and Headache.</p> <p>Observations in Resident #158's room on 12/7/15 at 11:57 AM and 4:08 PM, on 12/8/15 at 8:27 AM, 10:14 AM, 2:30 PM and 5:06 PM, on 12/9/15 at 9:45 AM and 1:00 PM, and on 12/10/15 at 8:50 AM, revealed the privacy curtain did not provide full visual privacy for Resident #158's bed.</p> <p>Observations in Resident #158's room on 12/10/15 at 8:59 AM, during perineal care, Certified Nursing Assistant (CNA) #1 knocked on the resident's door. CNA #3 stated, "Personal Care." CNA #1 entered the resident's room without waiting for permission. Resident #158 was uncovered when her door was opened to the hallway.</p> <p>5. Medical record review revealed Resident #255 was admitted to the facility on 11/25/15 with</p>	F 164	<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 all staff in all departments will be in-serviced on the Quality of Life – Dignity Policy by 1-10-16 by the Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) which indicates that staff will knock and request permission prior to entering a residents room and will close window blinds/shades and pull room curtains when providing personal care. The Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) will complete a</p>		

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F 164	Continued From page 3 diagnoses of Hypertension, Reflux Disease, Benign Prostatic Hyperplasia, Diabetes Mellitus, Hyperlipidemia, Parkinson's Disease, and Depression. Observations on 12/7/15 at 9:15 AM, outside Resident #255's room, revealed Resident #255 laying in bed with only a brief and socks with the door open. 6. Interview with the Director of Nursing (DON) on 12/9/15 at 4:35 PM, in the DON's office, the DON was asked what does she expect her staff to do to ensure residents' privacy. The DON stated, "Knock before entering, close the door and pull the curtain. We also have trouble with family members and other residents." The DON was asked what was done to prevent families and residents from going into rooms while care was being provided. The DON stated, "I've had to educate the families myself, and it is a constant battle to keep residents out."	F 164	dignity audit on twenty random residents twice weekly x 4 weeks, then weekly x 4 weeks, then monthly x 2 months to ensure staff knock and gain permission prior to entering a resident's room and pull the curtain and window blinds/coverings prior to performing personal care. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. The Director of Nursing or designee (Administrator, Assistant Director of Nursing, or Staff Development Coordinator) will present the results of the Dignity Audit to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director;	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on policy review, review of the Social Worker's (SW) job description, review of grievance report/logs, review of an incident report, medical record review, and interview, the facility failed to fully investigate and resolve	F 166	Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) monthly x 4 months for recommendations and/or follow up as needed.	

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F 166	<p>Continued From page 4</p> <p>grievances voiced by 2 of 51 (Residents #158 and 180) residents included in the stage 2 sample.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility's grievance policy documented, "...Social Services will oversee the implementation of the facility grievance procedure... The Social Services Director will coordinate the facility system for collecting grievances and tracking those grievances for timely and appropriate response..." 2. Review of the facility's SW job description documented, "...Maintain a written record of the resident's complaints and/or grievances that indicates the action taken to resolve the complaint and the current status of the complaint..." 3. Medical record review revealed Resident #158 was admitted to the facility on 8/30/13 with diagnosis of Hepatic Failure, Alcoholic Cirrhosis of Liver without Ascites, Carrier of Viral Hepatitis C, Vitamin D Deficiency, Hypokalemia, Vascular Dementia, Mood Disorder, Major Depressive Order, Insomnia, Chronic Pain Syndrome, Hypertension, Chronic Kidney Disease, and Headache. <p>Review of a grievance report for Resident #158 dated 6/29/15 at 1:58 PM documented, "...CNA [Certified Nursing Assistant] changing diaper but use no soap/water... CNA's complain a lot... wants to know how much in patient trust account... The CNA was trying to get her point across and CNA reported she did not want anyone to write her up... The resident did not</p>	F 166	<p><u>F166</u></p> <p>How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident # 158's grievance was addressed on 12-30-15. Resident # 180's grievance was addressed on 12-22-15.</p> <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>Social Worker # 1 is no longer employed with facility effective 12-11-15. All Social Workers will be in-serviced on the Grievance Policy by 1-10-16 by the Director of Nursing or designee (Administrator, Assistant Director of Nursing, or Staff Development Coordinator) to ensure all</p>	1-10-2016	

grievances will be handled within 5 business days and the results of the grievance investigation will be discussed with the resident or responsible party. The Administrator will review all

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F 166	<p>Continued From page 5 obtain a CNA name.</p> <p>There was no evidence that the family was notified and there is no signature identifying who completed the grievance resolution and the Chief Executive Officer did not sign the form.</p> <p>Interview with the Administrator on 12/9/15 at 12:50 PM, in the conference room, the Administrator stated, "There is no more information [on the concern dated 6/29/15]."</p> <p>4. Medical Record review revealed Resident #180 was admitted to the facility on 3/18/14 and readmitted on 4/28/14 with diagnoses of Reflux Disease, Diabetes Mellitus, Hemiplegia, Lack of Coordination, Aphasia, Hypertension, Hemiplegia, Disorder of Kidneys, Dysphagia, Gastrostomy and Cerebrovascular Disease with Cognitive Defects.</p> <p>Review of the grievance log from 7/3/15 to 12/7/15 revealed no documentation of missing personal items for Resident #180.</p> <p>Review of a nurses note dated 11/22/15 documented, "...RP [responsible party]visited [sign for and] informed staff that property, DVD [digital video disc] player was missing. Incident report completed. Administration aware..."</p> <p>Review of a facility incident report dated 11/22/15 documented, "...Location of Occurrence: Room 222... Property Involved: DVD player.. Incident Reported by: Family member/RP [responsible party]... Associate Involved: Unknown... Resident Condition at Time of Incident... Mental: Alert & [and] Oriented x [times] 1 Narrative of incident... RP was here visiting when she informed the staff</p>	F 166	<p>grievances and sign to ensure these are completed. A grievance audit will be completed by the Administrator or designee (Director of Nursing, Assistant Director of Nursing, or Staff Development Coordinator) weekly x 3 months to ensure all grievances are addressed within 5 business days, outcomes discussed with resident and/or responsible party, and reported to state if there is misappropriation of residents property. 100% of all staff in all departments will be in-serviced on the facility's Abuse Policy which includes what misappropriation of residents property is and that this is reportable to the state. In-servicing will be completed by the Director of Nursing or designee (Administrator, Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) by 1-10-16.</p>		

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F 166	<p>Continued From page 6 that her father's DVD player was missing. RP met with administrator while here..."</p> <p>Interview with CNA #1 on 12/8/15 at 6:05 PM, at the B hall nurses station, CNA #1 was asked if she had seen a DVD player in Resident #180's room. CNA #1 stated, "Yes, I remember he did have one." CNA #1 was asked how long it was missing. CNA #1 stated, "Couple of weeks maybe."</p> <p>Interview with SW #1 on 12/8/15 at 5:30 PM, in the SW's office, SW #1 was asked if the grievance log would be where missing personal items would be documented. SW #1 stated, "Yes, that is the bulk of our grievances."</p> <p>Interview with SW #1 on 12/9/15 at 8:45 AM, in the SW office, SW #1 was asked for the documentation for the missing DVD player for Resident #180. SW #1 stated, "I wrote up that grievance, but I can't find it. I may have given it to the Administrator." SW #1 was asked why the grievance was not logged in the grievance log. SW #1 stated, "Sometimes I fail to put in the log but I do have one." SW #1 was asked what her responsibility was when an item was missing and reported to her. SW #1 stated, "If it is missing money or clothing, I talk to [named Administrator]. If related to abuse I take concerns to the Administrator but he said he was not the person to take it to, that I was supposed to handle that and we talk to the family about resolution." SW #1 was asked if she interviewed and investigated the incident. SW #1 stated, "I would search other rooms because sometimes it ends up in other resident rooms." SW #1 was asked if she had searched rooms or interviewed anyone related to the missing DVD player. SW #1 stated, "I have</p>	F 166	<p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The Administrator or designee (Director of Nursing or Social Worker) will report the findings of the weekly Grievance Audit to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee 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.) monthly x 3 months for further follow up and/or recommendations as needed.</p>		

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F 166	Continued From page 7 not interviewed any staff." SW #1 was asked what is an acceptable period of time for an investigation for missing personal items. SW #1 stated, "Couple of days." Interview with the Director of Nursing (DON) on 12/9/15 at 9:30 AM, in the DON's office, the DON was asked for the incident report dated 11/22/15 that documented the missing DVD player. The DON stated, "I don't have that, we have to put those in the computer and it may be on the floor, let me call and see if it is in an office somewhere. The DON called the B Wing 2nd floor and asked someone if they had the report. The DON stated, she is going to look for it to see if she has that, we are supposed to give those to Social Services. I will keep looking to see if I have it or it is in the computer." The DON was asked what would Social Service do when they receive an incident report for resident's missing items. The DON stated, "We usually replace the item, we don't have to but within reasonable monetary value we will." The DON was then asked if the SW should do an investigation. The DON stated, "Yes, they should investigate, do interviews." There was no investigation documentation provided and the SW was unable to tell the process or what she had done to investigate the missing DVD player.	F 166	F224 How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 180's grievance was handled on 12-22-15 and the facility replaced the Digital Video Disc player. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected	1-10-2016	
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 224			

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F 224	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on policy review, review of an incident report, review of grievance logs, medical record review, and interview, the facility failed to ensure 1 of 51 (Resident #180) residents was free from misappropriation of personal property. The findings included: Review of the facility's abuse policy documented, "...Every resident has the right to be free from misappropriation of property... Misappropriation of resident property: The deliberate misplacement, exploitation, or wrongful temporary or permanent use of resident's belonging's... designated for exclusive use by the resident..." Medical Record review revealed Resident #180 was admitted to the facility on 3/18/14 and readmitted on 4/28/14 with diagnoses of Disorder of Kidneys, Diabetes Mellitus, Hemiplegia, Lack of Coordination, Aphasia, Cerebrovascular Disease with Cognitive Defects, Hypertension, Hemiplegia, Reflux Disease, Dysphagia and Gastrostomy. Resident #180's annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/27/15 and a quarterly MDS assessment with an ARD of 9/26/15 documented a Brief Interview for Mental Status (BIMS) of 2 indicating Resident #180 was moderately impaired cognitively.	F 224	What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur. Social Worker # 1 is no longer employed with facility effective 12-11-15. All Social Workers will be in-serviced on the Grievance Policy by the Director of Nursing or designee (Administrator, Assistant Director of Nursing, or Staff Development Coordinator) by 1-10-16 to ensure all grievances will be handled within 5 business days and the results of the grievance investigation will be discussed with the resident or responsible party. The Administrator will review all grievances and sign to ensure these are completed. A grievance audit will be completed by the Administrator or designee (Director of Nursing, Assistant Director of Nursing, or Staff Development Coordinator) weekly x 3 months to ensure all grievances		

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F 224	<p>Continued From page 9</p> <p>Nurse's note dated 11/22/15 documented, "...RP [responsible party] visited [sign for and] informed staff that property, DVD [Digital Video Disc] player was missing. Incident report completed. Administration aware..."</p> <p>Review of a facility incident report dated 11/22/15 documented, "...Location of Occurrence: Room 222... Property Involved: DVD player... Incident Reported by: Family member/RP [responsible party]... Associate Involved: Unknown... Resident Condition at Time of Incident... Mental: Alert & [and] Oriented x [times] 1 Narrative of incident and description of injuries... RP was here visiting when she informed the staff that her father's DVD player was missing. RP met with administrator while here..."</p> <p>Review of the grievance logs from 7/3/15 to 12/7/15 revealed no documentation of missing personal items for Resident #180.</p> <p>Interview with Certified Nursing Assistant (CNA) #1 on 12/8/15 at 6:05 PM, at the B hall nurses station, CNA #1 was asked if she had seen a DVD player in Resident #180's room. CNA #1 stated, "Yes, I remember he did have one." CNA #1 was asked how long it was missing. CNA #1 stated, "Couple of weeks maybe."</p> <p>Interview with Social Worker (SW) #1 on 12/9/15 at 8:45 AM, in the social services' office, SW #1 was asked for the documentation and investigation for the missing DVD player for Resident #180. SW #1 stated, "I wrote up that grievance, but I can't find it. I may have given it to the Administrator." SW #1 was asked why the grievance was not logged in the grievance log. SW #1 stated, "Sometimes I fail to put in the log,</p>	F 224	<p>are addressed within 5 business days, outcomes discussed with resident and/or responsible party, and reported to state if there is misappropriation of residents property.</p> <p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The Administrator or designee (Director of Nursing or Social Worker) will report the findings of the weekly Grievance Audit to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee 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.) monthly x 3 months for further follow up and/or recommendations as needed.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/10/2015
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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 224	<p>Continued From page 10</p> <p>but I do have one." SW #1 was asked what her responsibility was when an item was missing and reported to her. SW #1 stated, "If it is missing money or clothing, I talk to [named Administrator]. If related to abuse I take concerns to the Administrator but he said he was not the person to take it to, that I was supposed to handle that and we talk to the family about resolution." SW #1 was asked if she interviewed and investigated the incident. SW #1 stated, "I would search other rooms because sometimes it ends up in other resident rooms." SW #1 was asked if she had searched rooms or interviewed anyone. SW #1 stated, "I have not interviewed any staff." SW #1 was asked what was an acceptable period of time for investigation. SW #1 stated, "Couple of days." SW #1 was asked if she would report misappropriation to the state. SW #1 stated, "I would not be the one to do that."</p> <p>Interview with the Director of Nursing (DON) on 12/9/15 at 9:30 AM, in the DON's office, the DON was asked for the incident report dated 11/22/15 that documented the missing DVD player. The DON stated, "I don't have that. We are supposed to give those to Social Services." The DON was asked what would social service do when they receive an incident report for resident's missing items. The DON stated, "We usually replace the item. We don't have to but within reasonable monetary value we will." The DON was asked, should the social worker do an investigation? The DON stated, "Yes, they should investigate, do interviews."</p>	F 224	<p><u>F225</u></p> <p>How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Resident # 180's grievance was handled on 12-22-15 and the facility replaced the Digital Video Disc player.</p> <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>	1-10-2016
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		

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

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F 225	<p>Continued From page 11</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, review of an incident</p>	F 225	<p>What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>Social Worker # 1 is no longer employed with facility effective 12-11-15. All Social Workers will be in-serviced on the Grievance Policy by the Director of Nursing or designee (Administrator, Assistant Director of Nursing, or Staff Development Coordinator) by 1-10-16 to ensure all grievances will be handled within 5 business days and the results of the grievance investigation will be discussed with the resident or responsible party. The Administrator will review all grievances and sign to ensure these are completed. A grievance audit will be completed by the Administrator or designee (Director of Nursing, Assistant Director of Nursing, or Staff Development Coordinator) weekly x 3 months to ensure all grievances are addressed within 5 business days, outcomes discussed with resident and/or responsible party,</p>	
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F 225	<p>Continued From page 12</p> <p>report, review of grievance logs and interview, the facility failed to report and investigate an allegation of misappropriation for 1 of 51 (Resident #180) residents included in the stage 2 review.</p> <p>The findings included:</p> <p>Review of the facility's abuse policy documented, "...Every resident has the right to be free from... misappropriation of property... The facility has developed and instituted policies and procedures for... misappropriation of property. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences... The facility reports alleged violations, conduct, and investigation of all alleged violations, to the proper authorities and takes necessary corrective actions..."</p> <p>Review of a facility incident report dated 11/22/15 documented, "...Location of Occurrence: Room 222 [Resident #180's room]... Property Involved: DVD [digital video disc] player... Incident Reported by: Family member/RP [responsible party]... Associate Involved: Unknown... Narrative of incident... RP was here visiting when she informed the staff that her father's DVD player was missing. RP met with administrator while here..."</p> <p>Review of the grievance logs from 7/3/15 to 12/7/15 revealed no documentation of missing personal items for Resident #180.</p> <p>Medical Record review revealed Resident #180 was admitted to the facility on 3/18/14 and readmitted on 4/28/14 with diagnoses of Disorder of Kidneys, Diabetes Mellitus, Hemiplegia, Lack</p>	F 225	<p>and reported to state if there is misappropriation of residents property. Investigations will be comprehensive which will include interviewing staff members as appropriate.</p> <p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The Administrator or designee (Director of Nursing or Social Worker) will report the findings of the weekly Grievance Audit to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee 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.) monthly x 3 months for further follow up and/or recommendations as needed.</p>	
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F 225	<p>Continued From page 13 of Coordination, Aphasia, Cerebrovascular Disease with Cognitive Defects, Hypertension, Hemiplegia, Reflux Disease, Dysphagia and Gastrostomy.</p> <p>Resident #180's annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/27/15 and a quarterly MDS assessment with an ARD of 9/26/15 documented a Brief Interview for Mental Status (BIMS) of 2 indicating Resident #180 was moderately impaired cognitively.</p> <p>Review of a nurse's note dated 11/22/15 documented, "...4:00 PM RP visited [sign for and] informed staff that property, [Resident #180's] DVD player was missing. Incident report completed. Administration aware of incident..."</p> <p>Interview with Certified Nursing Assistant (CNA) #1 on 12/8/15 at 6:05 PM, at the B hall nurses station, CNA #1 was asked if she had seen a DVD player in Resident #180's room. CNA #1 stated, "Yes, I remember he did have one." CNA #1 was asked how long the DVD player had been missing. CNA #1 stated, "Couple of weeks maybe."</p> <p>Interview with Social Worker (SW) #1 on 12/8/15 at 5:30 PM, in the SW's office, SW #1 was asked if the grievance log would be where missing personal items would be. SW #1 stated, "Yes, that is the bulk of our grievances."</p> <p>Interview with SW #1 on 12/9/15 at 8:45 AM, in the SW's office, SW #1 was asked for the documentation for the missing DVD player for Resident #180. SW #1 stated, "I wrote up that grievance, but I can't find it. I may have given it to</p>	F 225		
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F 225	Continued From page 14 the Administrator." SW #1 was asked why the grievance was not logged in the grievance log. SW #1 stated, "Sometimes I fail to put in the log, but I do have one." SW #1 was asked what her responsibility was when an item was missing and reported to her. SW #1 stated, "If it is missing money or clothing, I talk to [named Administrator]. If related to abuse I take concerns to the Administrator but he said he was not the person to take it to, that I was supposed to handle that and we talk to the family about resolution." SW #1 was asked if she interviewed and investigated the incident. SW #1 stated, "I would search other rooms because sometimes it ends up in other resident rooms." SW #1 was asked if she had searched rooms or interviewed anyone. SW #1 stated, "I have not interviewed any staff." SW #1 did not answer the question about a room search. SW #1 was asked what an acceptable period of time for investigation would be. SW #1 stated, "Couple of days." SW #1 was asked if she would report misappropriation to the state. SW #1 stated, "I would not be the one to do that." The facility was unable to provide documentation that a complete and thorough investigation had been completed for the missing DVD player. The incident of the missing DVD player had not reported to the State Agency within 5 days as required.	F 225	<u>F250</u> How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident # 158's grievance was addressed on 12-30-15. Resident # 180's grievance was addressed on 12-22-15. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.	1-10-2016 ₁
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250	Social Worker # 1 is no longer employed with facility effective 12-11-15 All Social Workers will be in-serviced on the Grievance Policy by 1-10-16 by the Director of Nursing or designee	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 250	<p>Continued From page 15</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of a job description, policy review, review of a grievance report, review of grievance logs, review of an incident report, medical record review, and interview, the facility failed to ensure the social worker immediately, thoroughly and completely investigated grievances related to care and complaints of misappropriation of personal property for 2 of 51 (Resident #158 and 180) residents included in the stage 2 review.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the Social Worker's (SW) job description documented, "...Maintain a written record of the resident's complaints and/or grievances that indicates the action taken to resolve the complaint and the current status of the complaint..." 2. Review of the facility's grievance policy documented, "...Social Services will oversee the implementation of the facility grievance procedure... The Social Services Director will coordinate the facility system for collecting grievances and tracking those grievances for timely and appropriate response..." 3. Medical record review revealed Resident #158 was admitted to the facility on 8/30/13 with diagnosis of Hepatic Failure, Alcoholic Cirrhosis of Liver without Ascites, Carrier of Viral Hepatitis C, Mood Disorder, Chronic Pain Syndrome, Vitamin D Deficiency, Chronic Kidney Disease, Hypokalemia, Vascular Dementia, Hypertension, 	F 250	<p>(Administrator, Assistant Director of Nursing, or Staff Development Coordinator) to ensure all grievances will be handled within 5 business days and the results of the grievance investigation will be discussed with the resident or responsible party. The Administrator will review all grievances and sign to ensure these are completed. A grievance audit will be completed by the Administrator or designee (Director of Nursing, Assistant Director of Nursing, or Staff Development Coordinator) weekly x 3 months to ensure all grievances are addressed within 5 business days, outcomes discussed with resident and/or responsible party, and reported to state if there is misappropriation of residents property. 100% of all staff in all departments will be in-serviced on the facility's Abuse Policy which includes what misappropriation of residents property is and that this is reportable to the state. In-servicing will be completed by the Director of Nursing or designee (Administrator, Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) by</p>	
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F 250	<p>Continued From page 16</p> <p>Major Depressive Order, Insomnia, and Headache.</p> <p>Review of a grievance report for Resident #158 dated 6/29/15 at 1:58 PM documented, "...CNA [Certified Nursing Assistant] changing diaper but use no soap/water... CNA's complain a lot... wants to know how much in patient trust account... The CNA was trying to get her point across and CNA reported she did not want anyone to write her up... The resident did not obtain CNA name CNA's do not tell me their name... Action taken to resolve concern... research who had [Resident #158] between 3-11..."</p> <p>Review of the grievance log dated 6/29/15 documented, "...CNA changed diaper w/o [without] using soap/water. CNA complained a lot... Researched who took care of her during the times of 3 p [PM] -11 p..."</p> <p>The facility was unable to provide documentation the family was notified and there was no signature identifying who completed the grievance resolution.</p> <p>Interview with the Administrator on 12/9/15 at 12:50 PM, in the conference room, the Administrator stated, "There is no more information [on the concern dated 6/29/15]."</p> <p>4. Medical Record review revealed Resident #180 was admitted to the facility on 3/18/14 and was readmitted on 4/28/14 with diagnoses of Disorder of Kidneys, Diabetes Mellitus, Hemiplegia, Lack of Coordination, Aphasia, Cerebrovascular Disease with Cognitive Defects, Hypertension, Hemiplegia, Reflux Disease,</p>	F 250	<p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The Administrator or designee (Director of Nursing or Social Worker) will report the findings of the weekly Grievance Audit to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee 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.) monthly x 3 months for further follow up and/or recommendations as needed.</p>		

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F 250	<p>Continued From page 17 Dysphagia and Gastrostomy.</p> <p>Review of the grievance logs dated 7/3/15 to 12/7/15 revealed no documentation of missing personal items for Resident #180.</p> <p>Review of a nurses note dated 11/22/15 documented, "...RP [responsible party] visited [sign for and] informed staff that property, DVD [digital video disc] player was missing. Incident report completed. Administration aware of incident.."</p> <p>Review of a facility incident report dated 11/22/15 documented, "...Location of Occurrence: Room 222... Property Involved: DVD player... Incident Reported by: Family member/RP... Associate Involved: Unknown... RP was here visiting when she informed the staff that her father's DVD player was missing. RP met with administrator while here..."</p> <p>Interview with Certified Nursing Assistant (CNA) #1 on 12/8/15 at 6:05 PM, at the B hall nurses station, CNA #1 was asked if she had seen a DVD player in Resident #180's room. CNA #1 stated, "Yes, I remember he did have one." CNA #1 was asked how long the DVD player had been missing. CNA #1 stated, "Couple of weeks maybe."</p> <p>Interview with SW #1 on 12/8/15 at 5:30 PM, in the SW's office, SW #1 was asked if the grievance log would be where missing personal items would be. SW #1 stated, "Yes, that is the bulk of our grievances."</p> <p>Interview with SW #1 on 12/9/15 at 8:45 AM, in the SW's office, SW #1 was asked for the</p>	F 250		
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 250	<p>Continued From page 18</p> <p>documentation for the missing DVD player for Resident #180. SW #1 stated, "I wrote up that grievance, but I can't find it. I may have given it to the Administrator." SW #1 was asked why the grievance was not logged in the grievance log. SW #1 stated, "Sometimes I fail to put it in the log, but I do have one." SW #1 was asked what her responsibility was when an item was missing and reported to her. SW #1 stated, "If it is missing money or clothing, I talk to [named Administrator]. If related to abuse I take concerns to the Administrator but he said he was not the person to take it to, that I was supposed to handle that and we talk to the family about resolution." SW #1 was asked if she interviewed and investigated the incident. SW #1 stated, "I would search other rooms because sometimes it ends up in other resident rooms." SW #1 was asked if she had searched rooms or interviewed anyone. SW #1 stated, "I have not interviewed any staff." SW #1 did not answer the question about searching rooms of other residents. SW #1 was asked what is an acceptable period of time for investigation. SW #1 stated, "Couple of days."</p> <p>Interview with the Director of Nursing (DON) on 12/9/15 at 9:30 AM, in the DON's office, the DON was asked if the SW should do an investigation for missing personal property. The DON stated, "Yes they should investigate. Do interviews."</p> <p>The facility was unable to provide documentation of an investigation for the missing DVD player. The SW was unable to explain how she had investigated this incident.</p>	F 250		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280	<p><u>F280</u></p> <p>How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Care plan for Resident # 24 was updated on 12-28-15 to reflect that wound was resolved; Care plan for Resident # 109 was updated on 12-28-15 to reflect current compliance</p>	1-10-2016

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/10/2015
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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 280	<p>Continued From page 19</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, review of care plan attendance records, medical record review, and interview, the facility failed to revise the care plan related to pressure ulcers, nutrition, status of nothing by mouth (NPO) and/or failed to invite the resident or family member to the care plan meeting for 4 of 51 (Residents #24, 109, 158, and 202) residents included in the stage 2 review.</p> <p>The findings included:</p> <p>1. Review of the facility's "Care Plans - Comprehensive" policy documented, "...An individualized comprehensive care plan that includes measurable objectives and timetables to</p>	F 280	<p>status; Documentation for Resident # 158 will show that resident and family was invited for a care plan conference and will document if they declined to attend and reason if known. Family and/or resident will sign when they do attend; Care Plan for resident #202 was updated on 12-22-15 to reflect their current intake status. A care plan meeting was held on 12-28-15 for resident # 158 and she signed she attended.</p> <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. 100% of resident care plans will be audited for accuracy of their intake status, wound status, and compliance status by the Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) by 1-10-16.</p>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 280	<p>Continued From page 20</p> <p>meet the resident's, medical, nursing, mental and psychological needs is developed for each resident... Care Plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem area(s)... Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change..."</p> <p>2. Medical record review revealed Resident #24 was admitted to the facility on 6/26/09 with diagnoses of Hypothyroidism, Hyperlipidemia, Hypocalcemia, Dementia, Delirium, Depression, Hypertension, Peripheral Vascular Disease, Reflux Disease, Stage 3 Pressure Ulcer, Malaise, Anorexia, Osteoporosis, Paraplegia, and Cataract.</p> <p>The care plan dated 8/5/15 documented, "...Actual Alteration in skin integrity: Pressure Ulcer related to Pressure Stage 3 Site (R) [right] Ischial..."</p> <p>Documentation revealed the wound was resolved on 9/7/15.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator on 12/10/15 at 2:20 PM, in the MDS office, the MDS Coordinator was shown the care plan that documented pressure ulcer to R Ischium and was asked if this was a current care plan. The MDS stated, "No, it is not."</p> <p>2. Medical record review revealed Resident #109 was admitted to the facility on 7/2/10 and readmitted on 3/21/14 with diagnoses of Complications of a Vascular Prosthetic</p>	F 280	<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 , Minimum Data Set Nursing staff, and Social Workers will be in-serviced on the Resident/Family Participation – Assessment Care Plans Policy which indicates notices to be sent for care plan conferences, signatures obtained for those who attend, and documentation of refusal to attend and reason if known. 100% of licensed nursing staff including Minimum Data Set Nursing staff will be in-serviced on the Comprehensive Care Plan Policy. All in-servicing will be completed by the Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) by 1-10-16. A Care Plan Audit for new orders will be conducted 5x/weekly in morning stand up meeting x 3 months to determine if a resident change has been indicated, care plan updated, and appropriate notification has</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 280	<p>Continued From page 21 Device/Graft, Muscle Weakness, and End Stage Renal Disease.</p> <p>The care plan dated 7/14/14 and revised on 10/28/15 documented, "...Resident is non-compliant with diet and fluid restriction..."</p> <p>The facility was unable to provide documentation to substantiate Resident #109's non-compliance with her diet and fluid restriction.</p> <p>3. The facility's "Resident/Family Participation - Assessment/ Care Plans" policy documented, "...The resident and his/her family, and/or the legal representative... are invited to attend and participate in the resident's assessment and care planning conference... The Social Worker Director or designee is responsible for contacting the resident's family and for maintaining records of such notices..."</p> <p>The care plan attendance records for 3/24/15 and 9/16/15 did not document that Resident #158 was invited to her care planning meeting on 3/24/15 and 9/6/15. The facility was unable to provide documentation that Resident #158 or her family was invited to her care planning conferences on 3/24/15 and 9/16/15.</p> <p>Interview with Resident #158 on 12/7/15 at 3:40 PM, in Resident #158's room, Resident #158 was asked if the staff included her in decisions about her medicine, therapy, or other treatments. Resident #158 stated, "No."</p> <p>4. Medical record review revealed Resident #202 was admitted to the facility on 3/4/15 and readmitted 8/17/15 with diagnoses of Intracerebral Hemorrhage, Obstructive</p>	F 280	<p>occurred. Social Workers to keep a log indicating when care plan conference notices are sent to families, a copy of such, and a signature is to be obtained from the resident and/or responsible party or documentation if they fail to attend and reason (if known) on the care plan meeting form.</p> <p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Minimum Data Set Coordinator) will present the results of the Care Plan Audit to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee 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</p>	
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F 280	Continued From page 22 Hydrocephalus, Aphasia, Muscle Weakness, Hypertension, Atrial Fibrillation, Hemiplegia, Dysphagia, and Dysarthria. The care plan dated 3/17/15 documented, "...Offer fluids at meals, medication pass, snacks, and activities... Keep fluids within easy reach and assist as needed..." The nutritional progress note dated 11/17/15 documented, "...Diet: NPO..." The care plan was not updated to reflect Resident #202's NPO status. Interview with the 2nd floor unit manager (UM) on 12/10/15 at 8:56 AM, at the C wing nurses' station, the UM was asked if the care plan correctly reflected the resident's status. The UM stated, "No, she gets nothing by mouth."	F 280	Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) x 3 months for further recommendations and/or follow up as needed. <u>F282</u> How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to follow interventions for meal intake documentation, diet and/or pressure ulcer treatment for 3 of 51 (Residents #24, 180, and 257) residents included in the stage 2 review.	F 282	Resident #24's diet was communicated to the Dietary Manager on 12-11-15 and is now receiving a mechanical soft diet. Their intake is being recorded by Certified Nursing Assistants electronically and wound treatments are being documented as ordered by licensed nursing staff. Intake and wound treatments are being monitored via audits as listed below. Resident #180 is now receiving a pleasure tray as ordered and was communicated to dietary on 12-11-15 and with staff on 12-14-15. Resident # 257 is having their meal intake documented by Certified Nursing Assistants electronically and is being monitored via an audit as listed below.	1-10-2016

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

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F 282 Continued From page 23
The findings included:

1. Medical record review revealed Resident #24 was admitted to the facility on 6/26/09 with diagnoses of Hypothyroidism, Hyperlipidemia, Hypocalcemia, Dementia, Delirium, Depression, Hypertension, Peripheral Vascular Disease, Reflux Disease, Stage 3 Pressure Ulcer, Malaise, Anorexia, Osteoporosis, Paraplegia, and Cataract.

a. The care plan dated 10/2/15 documented, "...Diet as ordered..."

The Physician's telephone order dated 12/7/15 documented, "...Change diet texture to mechanical soft per RP [Responsible Party]'s request..."

Observation on 12/9/15 at 8:05 AM, in Resident #24's room revealed Resident #24 lying in bed when her breakfast tray was brought into her. Resident #24's breakfast consisted of orange juice, scrambled eggs, sausage, biscuit with jelly, oatmeal and a glass of water. The meal was not the texture of mechanical soft.

Observations on 12/9/15 at 5:47 PM, in Resident #24's room revealed Resident #24 in bed with dinner tray with a glass of water, french fries, hotdog on bun, and beans. The meal was not the texture of mechanical soft.

Observations on 12/10/15 at 7:59 AM, in Resident #24's room, revealed Resident #24's breakfast tray consisted of scrambled eggs, oatmeal, biscuit with jelly, sausage, orange juice, water, and milk. The meal was not the texture of mechanical soft.

F 282 **How the facility will identify other residents having the potential to be affected by the same deficient practice.**

All residents have the potential to be affected.

What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.

100% of Certified Nursing Assistants and licensed nursing staff to be in-serviced on the Meal Documentation Policy by the Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) by 1-10-16. 100% of licensed nursing staff and Dietary Personnel to be in-serviced on communicating a residents diet change and ensuring they receive the correct diet. The Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) are to print out the meal/fluid intake compliance report daily Monday through

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

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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 12/10/2015
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F 282	<p>Continued From page 24</p> <p>Interview with the Registered Dietician (RD) on 12/10/15 at 12:55 PM, in the RD's office, the RD was asked about Resident #24's dietary status. The RD stated, "Recently changed to mechanical soft texture on the 12/7/15. The RD was shown a diet slip dated 12/9/15 and was asked if a mechanical soft diet had been ordered, where would the change be reflected on the slip. The RD stated, "Under the texture on the diet slip." The RD was asked if she would expect a hot dog to be on a mechanical soft regular diet. The RD stated, "I would expect to see it cut up."</p> <p>Interview with the RD and the Dietary Manager (DM) on 12/10/15 at 1:15 PM, in the RD's office, the DM was asked is she considered a hotdog to be acceptable for a resident that was on a mechanical soft diet. The DM stated, "We grind our hot dogs." The DM was asked if you would expect the resident to receive a mechanical soft texture. The DM stated, "It should reflect the latest order."</p> <p>b. The care plan dated 10/2/15 documented, "...Monitor/document meal intake..."</p> <p>The meal intake reports for November and December 2015 did not document the dinner intake on 11/5/15, 11/19, 11/26, 11/30/15 and 12/2, 12/3, and 12/9/15.</p> <p>Interview with the Director of Nursing (DON) on 12/10/15 at 11:00 AM, in the DON office, the DON was shown the care plan that documented a goal to monitor/document food intake. The DON verified there was no documentation of food intake on these days. The DON was asked would you expect the meal intake to be documented on</p>	F 282	<p>Friday. Any staff member who failed to document meal intake is to come back in and document within 72 hours. A Dietary Audit for Meal Observation is to be completed on 20 random residents 3x/week x 4 weeks, then weekly x 4 weeks, then monthly x 2 months to ensure residents are receiving correct diet ordered. A Treatment Audit is to be completed 3x/week x 4 weeks, then weekly x 4 weeks, then monthly x 2 months looking for holes in the Treatment Administration Record.</p> <p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>Results of the Meal Intake Compliance, Dietary Meal Observation, and Treatment Audits are to be presented by the Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator) to the Quality Assurance Performance Improvement Committee (Members of the Quality</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 282	<p>Continued From page 25 these days. The DON stated, "It should."</p> <p>c. The care plan dated 10/16/14 and updated 12/8/15 documented, "...Pressure ulcer: Stage IV [4] - sacral area... Administer treatments as ordered by physician and document..."</p> <p>The treatment record" dated September 2015, October 2015 and November 2015 documented "...CLEANSE SACRAL W [wound] / [with] W/C, [wound cleanser] PAT DRY, APPLY SILVER COLLAGEN & [and] COVER W/ DRY DRSG [dressing] DAILY & PRN [as needed]."</p> <p>The treatment records revealed no documentation of dressing changes on 9/21/15, 10/17/15, or 11/28/15.</p> <p>Interview with the DON on 12/9/15 at 3:50 PM, in the DON's office, the DON confirmed treatments on 9/21/15, 10/17/15, and 11/28/15 were not documented as being done.</p> <p>2. Medical record review revealed Resident #180 was admitted to the facility on 3/18/14 and readmitted 4/28/14 with diagnoses of Disorder of the Kidney and Ureter, Diabetes Mellitus, Hemiplegia, Cerebrovascular Disease, Hypertension, Aphasia, Hemiplegia, Dysphagia, Reflux Disease, Symbolic Dysfunction, and Gastrostomy.</p> <p>The care plan dated 3/27/15 documented, "...Diet (pleasure tray) as ordered..."</p> <p>Observations on 12/8/15 at 6:05 PM, in Resident #180's room revealed resident did not receive a pleasure tray.</p>	F 282	<p>Assurance Performance Committee 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.) x 4 months for further recommendations and/or follow up as needed.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 282	Continued From page 26 Interview with Certified Nursing Assistant (CNA) #1 on 12/8/15 at 6:10 PM, at the B wing nurses' station, CNA #1 confirmed Resident #180 was not served a pleasure tray. 3. Medical record review revealed Resident #257 was admitted to the facility on 11/24/15 with diagnoses of Adenocarcinoma of the Prostate with Metastases to the Bone, Failure to Thrive, Hearing Loss, Left Facial Nerve Palsy, General Weakness, Constipation, Pressure Ulcer of Sacrum, and Congenital Fusion of the Cervical Spine. The care plan dated 11/30/15 documented, "...Monitor/document meal intake..." The meal intake record did not document the food intake on 11/26/15, 11/30/15, 12/2/15, and 12/3/15 for the dinner meal. Interview with the DON on 12/10/15 at 11:00 AM, in the DON office, the DON confirmed there was no documentation of Resident #257's meal intake on 11/26/15, 11/30/15, 12/2/15, and 12/3/15.	F 282	<u>F309</u> How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #24 is wearing geri-sleeves as of 12-28-15. Resident #158's physician was notified on 12-28-15 of non-documentation of medications being administered. No adverse reactions have been noted. Physician was notified of blood sugars noted to have been	1-10-2016
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced	F 309		

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

FORM APPROVED
OMB NO. 0938-0391

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F 309	<p>Continued From page 27</p> <p>by: Based on policy review, medical record review, observation and interview, the facility failed to ensure physician orders were followed for applying geri-sleeves, administering medications, notifying the physician of abnormal blood sugars or obtaining sliding scale insulin order before administering the insulin for 4 of 51 (Residents #24, 158, 179, and 257) residents included in the stage 2 review.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. A "Documentation of Medication Administration" policy documented, "...A nurse... shall document all medications administered to each resident on the resident's medication administration record... Administration of medication must be documented immediately after (never before) it is given... Documentation must include... Signature and title of the person administering the medication..." 2. Medical record review revealed Resident #24 was admitted to the facility on 6/26/09 with diagnoses of Major Depressive Disorder, Hypothyroidism, Hyperlipidemia, Hypocalcemia, Hypertension, Dementia, Malaise, Delirium, Peripheral Vascular Disease, Reflux, Stage 3 Pressure Ulcer to Sacrum, Stage 4 Pressure Ulcer of Sacral Area, Anorexia, Osteoporosis, Paraplegia, and Cataracts. <p>Physician's orders for July 2015 documented, "...GERISLEEVES TO BIL [Bilateral] ARMS TO PREVENT BRUISING & [and] SCRATCHING..."</p> <p>Observations on 12/9/15 at 8:05 AM, 10:45 AM, 1:57 PM, and 5:47 PM, and on 12/10/15 at 7:59</p>	F 309	<p>out of range on 12-28-15. Resident #179's physician was notified on 12-28-15 for non-documentation of medications. No adverse reactions have been noted. Resident # 257 expired 12-8-15.</p> <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>All licensed nurses will be in-serviced by the Director of Nursing or Designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) on the Insulin Administration Policy by 1-10-16. The Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) will audit twenty residents utilizing the</p>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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	<p>Continued From page 28</p> <p>AM, in Resident #24's room, revealed Resident #24 had no gerisleeves on her arms.</p> <p>Interview with the Director of Nursing (DON) on 12/10/15 at 3:05 PM, in the conference room, the DON was asked if she would expect a resident who has a physician's order for geri-sleeves to bilateral arms to prevent bruising and scratching to have them in place. The DON stated, "Um huh."</p> <p>3. An "After Hours Call Guidelines" policy documented, "...Please refer to the guide below before making an after-hours call to the provider... Specific Abnormal Labs... Glucose... Notify If glucose greater than 300 or less than 60..."</p> <p>Medical record review revealed Resident #158 was admitted to the facility on 8/30/13 with diagnoses of Hepatic Failure, Alcoholic Cirrhosis of Liver without Ascites, Carrier of Viral Hepatitis C, Vitamin D Deficiency, Hypokalemia, Vascular Dementia, Mood Disorder, Major Depressive Order, Insomnia, Chronic Pain Syndrome, Hypertension, Chronic Kidney Disease, and Headache.</p> <p>Review of Resident #158's October 2015 physician's orders documented Vitamin B Complex 1 by mouth (PO) daily, Levemir 15 units subcutaneously (SQ) twice daily (BID) and Vitamin D 2 50,000 units PO weekly.</p> <p>Review of Resident #158's Medication Administration Record (MAR) for October 2015 revealed the following medications were not documented as given as ordered by the physician:</p>	F 309	<p>Insulin/Physician Notification Audit 3x/week for 4 weeks, then weekly x 4 weeks, then monthly x 2 months to ensure proper physician notification for blood sugars outside of ordered parameters. 100% of licensed nurses will be in-serviced on the Medication Administration Policy by the Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator, or Unit Managers) which discusses how to properly document medications that are administered by 1-10-16. A Medication Documentation Audit will occur on 20 random residents 3x/week x 4 weeks, then weekly x 4 weeks, then monthly x 2 months looking for any non-documentation issues for medications and geri-sleeves and further follow up that may need to occur.</p> <p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p>	
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F 309	<p>Continued From page 29</p> <p>a. Vitamin B Complex on 10/17/15 at 9:00 AM. b. Levemir 15 units subcutaneously (SQ) on 10/18/15 at 9:00 AM. c. Vitamin D 2 50,000 units PO weekly on 10/23/15 at 9:00 AM.</p> <p>Review of Resident #158's November 2015 physician's orders documented Levothyroxine 100 micrograms (mcg) PO daily, Omeprazole 40 milligrams (mg) PO before breakfast, Fluticasone 50 mcg 2 sprays each nostril daily, Phos-Nak Packet 1 PO daily, Carvedilol 12.5 mg PO BID and Multivitamin 1 PO daily.</p> <p>Review of Resident #158's MAR for November 2015 revealed the following medications were not documented as given as ordered by the physician:</p> <p>a. Levothyroxine 100 mcg on 11/26/15 and 11/28/15 6:00 AM. b. Omeprazole 40 mg PO before breakfast on 11/28/15 at 6 AM. c. Fluticasone 50 mcg 2 sprays each nostril on 11/30/15 at 9:00 AM. d. Phos-Nak Packet 1 PO on 11/30/15 at 9:00 AM. e. Carvedilol 12.5 mg PO on 11/30/15 at 5:00 PM. f. Multivitamin 1 PO on 11/30/15 at 6:00 PM.</p> <p>Review of Resident #158's December 2015 physician's orders documented Provide Gold 30 milliliters (ml) PO daily, Xifaxin 550 mg PO BID, Levemir 20 units SQ BID, and Levothyroxine 100 mcg PO daily.</p> <p>Review of Resident #158's MAR for December 2015 revealed the following medications were not documented as given as ordered by the physician:</p>	F 309	<p>The Director of Nursing or designee (Assistant Director of Nursing, Staff Development Coordinator) will present the results of the Insulin/Physician Notification Audit and the Medication Documentation Audit to the Quality Assurance Performance Improvement Committee (Members of the Quality Assurance Performance Committee 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.) x 4 months for further recommendations and/or follow up as needed.</p>		

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F 309	<p>Continued From page 30</p> <p>a. Provide Gold 30 ml on 12/2/15 and 12/4/15 at 9:00 AM.</p> <p>b. Xifaxin 550 mg on 12/5/15 and 12/6/15 at 9:00 AM and 5:00 PM.</p> <p>c. Levemir 20 units on 12/7/15 and 12/10/15 at 9:00 AM.</p> <p>d. Levothyroxine 100 mcg on 12/8/15 and 12/9/15 at 6:00 AM.</p> <p>Physician's orders for October, November, and December 2015 documented, "...NOTIFY PROVIDER IF BLOOD SUGAR IS LESS THAN 60 OR GREATER THAN 300... HYPERGLYCEMIA PROTOCOL / SLIDING SCALE INSULIN: WE ARE UTILIZING A NO SSI [sliding scale insulin] COVERAGE PROTOCOL SINCE IT IS A REACTIVE RESPONSE TO ELEVATED BGS [blood glucoses]. THE USE OF RAPID ACTING OR SHORT ACTING INSULIN ORDERED BY THE PROVIDER IN RESPONSE TO ELEVATED BG [blood glucose] > [greater than] 300 IS REACTIVE APPROACH TO TREATING HYPERGLYCEMIA... ONLY THOSE SEEING AN ENDOCRINOLOGY FOR BRITTLE DIABETES MAY FOLLOW THE PROTOCOL FOR THE USE OF SSI COVERAGE..."</p> <p>Review of Resident #158's diabetic monitoring logs for October 2015 revealed the following blood sugars results greater then 300 with no physician notification per policy or as ordered:</p> <p>a. 322 on 10/1/15 at 9:00 PM.</p> <p>b. 334 on 10/3/15 at 9:00 PM.</p> <p>c. 323 on 10/8/15 at 9:00 PM.</p> <p>d. 486 on 10/11/15 at 9:00 PM.</p> <p>e. 318 on 10/12/15 at 6:30 AM.</p> <p>f. 332 on 10/12/15 at 9:00 PM.</p> <p>g. 306 on 10/13/15 at 9:00 PM.</p> <p>h. 349 on 10/19/15 at 9:00 PM.</p>	F 309		
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F 309	<p>Continued From page 31</p> <p>i. 350 on 10/24/15 at 9:00 PM. j. 343 on 10/25/15 at 9:00 PM. k. 307 on 10/28/15 at 6:30 AM. l. 302 on 10/28/15 at 9:00 PM. m. 350 on 10/30/15 PM.</p> <p>On 10/11/15 at 9:00 PM a BG was 486 and sliding scale insulin of 5 units was administered.</p> <p>The facility was unable to provide a physicians order for the sliding scale dose of insulin that was administered on 10/11/15.</p> <p>Review of Resident #158's diabetic monitoring logs for November 2015 revealed the following blood sugars results greater then 300 with no physician notification per policy or as ordered: a. 308 on 11/8/15 at 6:30 AM. b. 350 on 11/15/15 at 9:00 PM. c. 343 on 11/22/15 at 6:30 AM. d. 335 on 11/22/15 at 9:00 PM. e. 325 on 11/28/15 at 9:00 PM. f. 319 on 11/29/15 at 6:30 AM.</p> <p>Review of Resident #158's diabetic monitoring logs for December 2015 revealed the following blood sugars results greater then 300 with no physician notification per policy or as ordered: a. 315 on 12/3/15 at 6:30 AM. b. 393 on 12/3/15 at 9:00 PM. c. 315 on 12/5/15 at 9:00 PM. d. 306 on 12/6/15 at 6:30 AM. e. 341 on 12/6/15 at 9:00 PM. f. 322 on 12/7/15 at 6:30 AM.</p> <p>Interview with the assistant director of nursing (ADON) on 12/10/15 at 12:51 PM, in the conference room, the ADON was asked what she expected the nurses to do when a blood glucose</p>	F 309			

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F 309	<p>Continued From page 32</p> <p>was outside of an ordered parameter. The ADON stated, "Doctor should be called."</p> <p>4. Medical record review revealed Resident #179 was admitted to the facility on 10/19/15 with the diagnoses of Convulsions, Symbolic Dysfunction, Muscle Weakness, Constipation, and Lung Mass.</p> <p>Review of Resident #179's MAR for 11/22/15 revealed the following medications were not documented as given as ordered by the physician: Polyethylene Glycol 17 grams (GM) PO daily, Bisacodyl enteric coated (EC) 5 mg PO daily, and Docusate Sodium 100 mg PO daily.</p> <p>5. Medical record review revealed Resident #257 was admitted to the facility on 11/24/15 with diagnoses of Adenocarcinoma of the Prostate with Metastases to the Bone, Failure to Thrive, Hearing Loss, Left Facial Nerve Palsy, General Weakness, Constipation, Pressure Ulcer of Sacrum, and Congenital Fusion of the Cervical Spine.</p> <p>A physician's order dated 12/7/15 documented, "...Start Morphine ER [extended release] 10 mg q [every] 12 hours PO..."</p> <p>Review of the MAR revealed Morphine ER 10 mg was not given as scheduled on 12/8/15 at 6:00 AM.</p> <p>Review of Resident #257's November 2015 physician's orders documented Hydrocodone Acetaminophen (APAP) 5-325 PO every 6 hours, Vigamox 0.5 percent (%) eye drops 1 drop to left eye every 4 hours, and Occular lubricant to left eye every 4 hours.</p>	F 309			

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F 309	<p>Continued From page 33</p> <p>Review of Resident #257's MAR for November 2015 revealed the following medications were not documented as given as ordered by the physician:</p> <p>a. Hydrocodone APAP 5-325 PO on 11/30/15 at 4:00 AM, 12/4/15 at 6:00 PM and on 12/7/15 at 12:00 PM.</p> <p>b. Vigamox 0.5% eye drops 1 drop to left eye on 11/26/15 and 11/27/15 at 9:00 PM.</p> <p>c. Ocular lubricant to left eye on 11/26/15, 11/27/15, and 11/28/15 at 1:00 AM, and on 11/26/15, 11/27/15, 11/28/15, 11/29/15, and 11/30/15 at 5:00 AM.</p> <p>Review of Resident #257's December 2015 physician's orders documented Mucinex 600 mg PO BID, Hydrocodone APAP 5-325 PO every 6 hours, and Vigamox 0.5% eye drops 1 drop to left eye every 4 hours.</p> <p>Review of Resident #257's MAR for December 2015 revealed the following medications were not documented as given as ordered by the physician:</p> <p>a. Mucinex 600 mg on 12/7/15 at 5:00 PM.</p> <p>b. Docusate Sodium 100 mg on 12/4/15 at 5:00 PM.</p> <p>c. Hydrocodone APAP 5-325 on 12/4/15 at 6:00 PM and on 12/7/15 at 12:00 PM.</p> <p>d. Vigamox 0.5% eye drops 1 drop to left eye on 12/4/15 at 10:00 PM.</p> <p>5. Interview with the DON on 12/10/15 at 4:10 PM, in the DON's office, the DON confirmed the medications were not given as ordered by the physician. The DON was asked if she would expect medications to be given as ordered by the physician. The DON stated, "They should."</p>	F 309		

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