ND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		445118	8. WING		11/07/2013
	PROVIDER OR SUPPLIER	EHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 3030 WALNUT GROVE RD MEMPHIS, TN 38111	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 164 SS=D	The resident has the confidentiality of his records. Personal privacy ind medical treatment, communications, per meetings of family a does not require the room for each resided Except as provided section, the resident release of personal individual outside the The resident's right and clinical records resident is transferre institution; or record The facility must kee contained in the resident release is required in healthcare institution contract; or the resident by: Based on policy revides determined the facili privacy for 1 of 4 (R	ENTIALITY OF RECORDS e right to personal privacy and or her personal and clinical cludes accommodations, written and telephone ersonal care, visits, and and resident groups, but this e facility to provide a private ent. in paragraph (e)(3) of this t may approve or refuse the and clinical records to any e facility. to refuse release of personal does not apply when the ed to another health care release is required by law. ep confidential all information ident's records, regardless of methods, except when by transfer to another n; law; third party payment	F 16	 4 The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficie To remain in compliance with all fe state regulations, Ashton Place Re Care Center has taken or will take set forth in the following plan of cor- The following plan of correction co- the Center's allegation of complia alleged deficiencies cited have be be corrected by the date or dates 1. Resident #231 was assess well as all other residents a found to be free of harm as result of the alleged failed p 2. The alleged failed practice potential to affect all reside the facility. 3. Nurse #6 was in-serviced b DON/designee regarding p medication pass administra 11-8-13 and all other nurse received in-servicing 11-8- thru 11-15-13 by DON/desi DON/designee will ensure is maintained by observatio The results of any concern communicated to the DON on a weekly basis for the n months. 4. The results of the above of will be referred to the Quali Assurance Program on a n basis for the next three (3) for further recommendatior needed. 	ncies herein. aderal and ahab and the actions prrection. mostitutes nce. All en or will indicated. ed as ind all a practice. has the nts within by the rivacy during ation on is 13 gnee. The privacy ons daily. s will be or designee ext three pservations ity nonthly months
	The findings include				
\	pA.K	ERISUPPLIER REPRESENTATIVE'S SIG		CED Administrate	(X6) DATE)Y 11-18-

If continuation silect Page 1 of 23

PRINTED: 11/14/2013

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		AND HUMAN SERVICES				FORM	11/14/2013 APPROVED 0938-0391
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		445118	B. WING	; 		11/	07/2013
NAME OF I	PROVIDER OR SUPPLIER		L =	[s	TREET ADDRESS, CITY, STATE, ZIP CODE		
ASHTON	PLACE HEALTH & R				030 WALNUT GROVE RD IEMPHIS, TN 38111		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BĘ	(X5) COMPLETION DATE
F 164	Continued From pa	ge 1	F ·	164			
	Statement Provid medication pass, th curtains, closing do Observations in Re at 8:25 AM, Nurse # #231's medications Endoscopy Gastros door and providing	documented, "Policy e for privacy during is includes pulling privacy ors" sident #231's room on 11/6/13 #6 administered Resident through the Percutaneous stomy Tube without closing the full visual privacy.					
F 241 SS=D	INDIVIDUALITY The facility must pro- manner and in an e enhances each resi full recognition of hi This REQUIREMEN by:	AND RESPECT OF omote care for residents in a nvironment that maintains or ident's dignity and respect in s or her individuality. NT is not met as evidenced	F2	241	 All eight (8) residents assigned to Restorative Dining program were assessed by the DON or designed were found to be free of harm as result of the alleged failed practic All residents have the potential to harmed by this alleged deficient practice. In-servicing was provided to CNA and #3 regarding placing straws 	ee and a ce. o be A #2	12/6/13
	interview, it was def ensure the five residining table were the (lunch on 11/4/13 a dining observations				Shasta cans. This in-servicing wa provided to Nurse #5. Staff were instructed to pour all drinks that of in cans/cartons into glasses in order to adhere to the fine dining	as also e come	
	Guidelines" policy d promote quality of li independence and	cility's "Fine Dining Program locumented, "Purpose: To			policy. All verbalize understandi the process. The restorative nur monitor this process and docume observations three (3) times a week for four (4) weeks and ther weekly thereafter for eight (8) we ensure compliance is obtained.	rse will ent	

Facility ID: TN6007

If continuation sheet Page 2 of 23

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		445118	B. WING			11/	07/ 201 3
NAME OF	PROVIDER OR SUPPLIER		·	STREET ADDRE	SS, CITY, STATE, ZIP CODE		
ASHTON	PLACE HEALTH & F	EHAB CENTER		3030 WALNUT MEMPHIS, TN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROI DEFICIENCY)	D BE	(XS) COMPLETION DATE
F 241	 11/4/13 at 11:45 AI at the restorative di Assistant (CNA) #2 residents' cans of s kitchen staff poured the residents in the the residents seate table. 3. Observations in 11/5/13 at 5:00 PM 	ge 2 the main dining room on <i>A</i> , revealed 5 residents seated ning table. Certified Nursing placed a straw in all 5 hasta cola. At 12:00 PM, d shasta cola into glasses for main dining room but not for d ate the restorative dining the restorative dining room on , CNA #3 placed a straw in a a resident at the restorative	F 241	4. The res will be Assura for the	sults of the above obsen referred to the Quality nce Program on a monti next three (3) months fo nendations as needed.	nly basis	
	(DM) office on 11/6 asked if there was restorative table we while the other resi The DM stated, "No straw for each drink During an interview 11/6/13 at 3:33 PM residents at the residents their colas poured i	in the conference room on Nurse #5 was asked why the torative table did not have nto a glass or cup. Nurse #5					
	HIGHEST WELL B Each resident mus provide the necess or maintain the high mental, and psycho	CARE/SERVICES FOR	F 309	assess harm a practice 2. The all potentia the fac	nt #231 and Resident #2 ed and found to be free s a result of the alleged e. eged deficient practice h al to affect all residents v ility. All remaining resid ssessed as well and fou	from deficient as the within ents	12/6/1

Facility ID: TN6007

If continuation sheet Page 3 of 23

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		AND HUMAN SERVICE			P		11/14/2013 APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			O		0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		AULTIP IILDING			E SURVEY PLETED
		445118	8. WI	NG		11/	07/2013
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
				3	3030 WALNUT GROVE RD		
ASHION	PLACE HEALTH & R	ERAD VENTER			MEMPHIS, TN 38111		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PR	d EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	8E -	(X5) COMPLETION DATE
F 309	by: Based on policy re- observation and inte- facility failed to follo medication adminis #231 and 232) resid medication adminis The findings include 1. Review of the fai Medications" policy Statement Medica a safe and timely m Policy Interpretation Medications must b with the orders" 2. Medical record n documented an adr diagnoses of Cereb Peripheral Arterial I Diabetes Mellitus, I	NT is not met as evidence view, medical record revie erview, it was determined w physician's orders for tration for 2 of 4 (Resident lents observed during tration.	ed in nce	F 309	free from any harm as a result of alleged deficient practice. 3. The four LPN's that failed to con- follow physician orders have been in-serviced regarding the errors and have been given the policy and procedure for medica administration. All involved vert an understanding of their error a time and will require a follow up medication pass with the facility Development RN. An in-service be provided on 11-8-13 and be ongoing thru 11-22-13 regarding reconciliation of monthly orders and the importance of 24-hour chart checks. The DON or designee will ensur- validate that upcoming MARS a reconciled appropriately. The S Development Coordinator or de will perform a medication pass assessment with two (2) nurses week for four (4) weeks and will perform one (1) medication pass review with one (1) nurse week the next eight (8) weeks to ensu- accuracy.	npletely ation palize at this Staff will signee per l then s y for ure	
	10/21/13 document [milligrams] BID [tw Zinc Sulfate 220 mg the Medication Adm	ed, "Vitamin C 500 mg ice daily] X [times] 14 days g daily X 14 days" Revie hinistration Record (MAR) ugh 10/31/13 documented	s w of		 The results of the above observ will be referred to the Quality Assurance Program on a month basis for the next three (3) mon further recommendations as ne 	ily ths for	
FORM CMS-25	Resident #231 rece Zinc Sulfate 220 m Review of the MAR 11/30/13 document	ived Vitamin C 500 mg ar g for 10 days in October 2 dated 11/1/13 through ed Resident #231 receive and Zinc Sulfate 220 mg fo gh 11/6/13).	ud 013. d or 6	Fa			Page 4 of 23

		I AND HUMAN SERVICES					FORM	11/14/2013 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(· ·		TIPLE CONSTRUCTION	·		E SURVEY IPLETED
		445118	B. WING	;_			11/	07/2013
	PROVIDER OR SUPPLIER	EHAB CENTER			STREET ADDRESS, CITY, STATE 3030 WALNUT GROVE RD MEMPHIS, TN 38111	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD	8E	(X5) COMPLETION DATE
F 309	Continued From pa	ge 4	F:	30	99] • 1
	at 8:25 AM, Nurse a mg and Zinc Sulfate The physician's ord Zinc Sulfate 220 mg 14 days. The order 11/4/13 doses were During an interview	sident #231's room on 11/6/13 #6 administered Vitamin C 500 e 220 mg to Resident #231. er for Vitamin C 500 mg and g was written on 10/21/13 for should have stopped after the e given. in the conference room on the Director of Nursing						
	(DON) was asked a 500 mg and Zinc Si #231. The DON sta [10/21/13] it shou [November] that [reflected upon here compare the Octob	about the order for Vitamin C ulfate 220 mg for Resident ited, "added that day Id have stopped on the 4th stop date] should have been [on the MAR] nurse should er MAR to the subsequent bould be adjusted I would						
	(RD) office on 11/6 asked about the ord receive Vitamin C 5 mg. The RD stated [Resident #231] r and Juven for Vita a day for 14 days 14 days order wa have started on tha	in the Registered Dietitian's (13 at 2:20 PM, the RD was der for Resident #231 to 500 mg and Zinc Sulfate 220 . "on the 21st I saw him ecommended Vitamin C, Zinc amin C we do a protocol twice Zinc Sulfate 220 mg daily for s written for the 21st should it day Sunday [11/3/13] was id have been given"						
	documented an ad readmission date o Anxiety, Muscle We Hypertension, Anor	review for Resident #232 mission date of 6/21/11 with a f 10/15/13 with diagnoses of eakness, Osteoarthritis, rexia, Chemical Exposure and h. Review of the admission						

		AND HUMAN SERVICES					RINTED FORM MB NO	APPF	OVED
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		PLE CONSTRUCTION G	- <u> </u>	(X3) DAT		/EY
		445118	B. WING	G_			11/	07/20	13
NAME OF F	PROVIDER OR SUPPLIER			Ì	STREET ADDRESS, CITY, STAT	E, ZIP CODE			·•
ASHTON	PLACE HEALTH & R	EHAB CENTER			3030 WALNUT GROVE RD MEMPHIS, TN 38111				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD	BE	COMP	(5) LETION ATE
	physician on 10/16/ "Fluconazole 100 [every] Day X 7 day 10/15/13 through 10/ #232 received Fluco from 10/16/13 through 11/ "FLUCONAZOLE TABLET BY MOUT (ANTI-FUNGAL)" Resident #232 rece from 11/1/13 throug doses. Review of a fax mean dated 11/6/13 throug doses. Review of a fax mean dated 11/6/13 docum [Pharmacist name]. Subject Fluconazo written as Fluconazo mouth daily for 7 da 10/15/13It should dropped from the M During an interview 11/6/13 at 1:35 PM, #232 received 5 dos 11/1/13 through 11/ mistakenly continue MAR, The DON star [named Pharmacist mistakenly sent the 4. During an intervi lobby on 11/6/13 at about making sure to medications are give	 13 and signed by the 13 documented, mg tablet po [by mouth] Q s" Review of the MAR dated 0/31/13 documented Resident onazole 100 mg for 7 days igh 10/22/13. The MAR dated 30/13 documented, 100 MG TABLET TAKE 1 H ONCE DAILY The MAR documented ived Fluconazole 100 mg daily ih 11/5/13 for a total of 5 ssage from the Pharmacist mented, "From To [facility name] DON ole Order The order was ole 100mg take one tablet by iys with a start date of i have automatically been AR" in the conference room on the DON confirmed Resident ses of Fluconazole from 5/13 and the pharmacy had dd the order on the November ted she had spoken with j who admitted pharmacy had doses to the facility. 		30					
FORM CMS-25	Stated, "It's my sta 67(02-99) Previous Versions			F	acility (D: TN6007	If continuat	ion sheet	Page	6 of 23

-	TH AND HUMAN SERVICES		Ph	FORM APPRO	
_CENTERS FOR MEDICA	RE & MEDICAID SERVICES			MB NO. 0938-0	-
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	Y
	445118	B, WING		11/07/2013	3
NAME OF PROVIDER OR SUPPL	ER		STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHTON PLACE HEALTH	& REHAB CENTER		3030 WALNUT GROVE RD MEMPHIS, TN 38111		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE	
resident, the fac who enters the f does not develo individual's clinic they were unave pressure sores of services to prom prevent new sor This REQUIREN by: Based on review Advisory Panel Prevention" quid medical record r it was determine pressure ulcer b necrosis for 1 of residents review pressure ulcers, ulcer before it by resulted in an ac The findings inc Review of the N Prevention quid "[page] 9 Unst thickness skin o thickness tissue ulcer is complet tan, gray, green brown, black) in	PRESSURE SORES mprehensive assessment of a lity must ensure that a resident acility without pressure sores o pressure sores unless the al condition demonstrates that idable; and a resident having eceives necessary treatment and ote healing, prevent infection and es from developing. NENT is not met as evidenced w of the "National Pressure NPUAP] Pressure Ulcer k reference guide, policy review, eview, observation and interview, d the facility failed to identify a efore it became unstageable with 6 (Resident #198) sampled ed of the 6 residents with The failure to identify a pressure became unstageable with necrosis tual harm for Resident #198.		 All residents have the potential t affected by this alleged deficient practice. Resident #198 had already been identified by the fac having an facility acquired pressi- has been receiving treatment sin 4-12-13. The wound continues to improvement at this time. All other residents within the fac received a head-to-toe body aud facility treatment nurses. No oth areas of concern have been ider The facility has re-educated all o staff on the facility turning and repositioning schedule every two A copy of this schedule has been placed on the MAR as well as the care guide. A turn and reposition form has also been created and o utilized by clinical staff showing documentation of such. The faci revised the weekly nurses skin assessment audit to ensure appropriate assessments are cor as required. The nurses will be in-serviced on this skin assessment audits from 11-8-13 to 11-15-13 I DON or designee. The Unit Man will review these audits complete Clinical meetings Monday-Friday completion. The results of the above observ will be referred to the Quality Assurance Program for the next (3) months for further recommen as needed. 	ce o show ility it by er tiffied. clinical o hours. CNA will be lity has will be lity has mpleted ent by lagers id in for vations three	2/6/13

Facility ID: TN6007

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	TMENT OF HEALTH							FORM A	11/14/2013 APPROVED 0938-0391
	f of deficiencies of correction		VSUPPLIER/CLIA ATION NUMBER:			LE CONSTRUCTION		(X3) DATE COMP	SURVEY
		4	45118	B. WING	;			11/0	7/2013
NAME OF	PROVIDER OR SUPPLIER	1	<u> </u>		5	TREET ADDRESS, CITY, STAT	FE, ZIP CODE		
ASHTON	I PLACE HEALTH & R	REHAB CENTE	ĒR			030 WALNUT GROVE RD AEMPHIS, TN 38111			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD	BE !	(X5) COMPLETION DATE
F 314	Continued From par determined; but it w III [3] or IV [4] [par regularly for signs of assessment of the early signs of press inspection should in localized heat, eder especially in individ skin [page] 13 6 pressure damage of Many different type been reported as he damage 7. Docur noting details of any pressure damage Review of the NAPP Prevention quick re "[page] 11 6. Use assessment that ind assessment that ind assessment that ind assessment to eval skin 10. Conduct on admission, and a frequently as requir condition [page] 1 skin assessment is screening policy in settings 3. Inspect redness in individua pressure ulceration may need to be incl deterioration in ove assessment of the early signs of press Review of the facilit documented, "The be recorded in the facility any change in the facility	vill be either a gej 12 3. In of redness C skin is neces sure damage. nclude assess ma, or indura- uals with dark b. Observe the aused by me s of medical of aving caused nent all skin a y pain possible." UAP Pressure ference guide a structured cludes a com luate any alte a structured cludes a com log of the ris place in all he it skin regular als identified a . The frequer reased in res rall condition. skin is neces sure damage.	spect skin Ongoing sary to detect 4. Skin sment for tion (hardness), kly pigmented e skin for dical devices devices have pressure assessments, ly related to e Ulcer e documented, approach to risk prehensive skin rations to intact risk assessment ularly and as ividual's e that a complete sk assessment ealth care ty for signs of as being at risk of ney of inspection ponse to any Ongoing sary to detect oning" policy formation should dical record	F	314				
FORM CMS-2	67(02-99) Previous Versions	• • • • • • • • • • • • • • • • • • • •	Event ID: 31HM11	}	Fa	cility ID: TN6007	If continual	ion sheet I	Page 8 of 23

-		AND HUMAN SERVICES				(INTED: 11/14/20 FORM APPROVI <u>//B N</u> O: 0938-03	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		445118	B. WING			11/07/2013	
NAME OF P	ROVIDER OR SUPPLIER	<u>. </u>	- L	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
ASHTON	PLACE HEALTH & F	REHAB CENTER		3030 WALNUT GROVE RE MEMPHIS, TN 38111	0		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN	AN OF CORRECTION VE ACTION SHOULD I OT THE APPROPR ICIENCY)	BE COMPLETIO	
F 314	Continued From pa	ge 8	F 3	14			
	documented, "Ob any redness, rashe irritation, reddish or pressure point, blist following informatio resident's ADL [acti and/or in the reside assessment data (. on the resident's sk shower/tub bath Na areas that may nee Medical record revit documented an adr with diagnoses of H Disorder, Aphasia, Coordination, Cong Cardiomyopathy, D Hyperlipidemia, Os Anuria, Anemia, Ur annual Minimum Da documented Reside develop pressure u documented reside for positioning and quarterly MDS date stage 4 sacral pres Review of the care documented, "Po Approaches Mon	ew for Resident #198 mission date of 1/28/13 and lemiplegia, Dysphagia, Mental Gastrostomy, Lack of estive Heart Failure, ebility, Hypertension, teoporosis, Oliguria and inary Retention. Review of an ata Set (MDS) dated 2/4/13 ent #198 was at risk to loers and section G nt is totally dependent on staff all ADLs. Review of the id 10/28/13 documented one sure ulcer.					
	documented, "Ac Pressure Ulcer rela Deep Tissue Injury	care plan dated 4/12/13 tual Alteration in skin integrity: ted to Stage SDTI [Suspected] Rt [right] buttock					
	Approaches Pres	sure ulcer risk assessment Obsolete Event ID:31HM		Facility ID: TN6007		ion sheet Page 9 of	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 445118 B. WING 11/07/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3030 WALNUT GROVE RD ASHTON PLACE HEALTH & REHAB CENTER MEMPHIS, TN 38111 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION (X4) ID QI (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 314 Continued From page 9 F 314 weekly... Skin assessment weekly and prn [as needed]... Weekly pressure ulcer healing assessment by the wound team ... " Review of the care plan dated 10/31/13 documented, "Actual Alteration in skin integrity: Pressure Ulcer: Stage 4 sacral... Approaches... Skin assessment weekly and prn ... " Review of the weekly pressure ulcer records revealed the following: a. 4/12/13 - sacral pressure ulcer "...Stage SDTI ... wound bed Maroon/nec [necrotic] ... " The sacral ulcer was not identified until it was noted as being necrotic on 4/12/13, which resulted in actual harm. b. 4/17/13 - sacral pressure ulcer "...Stage U [unstageable] wound bed 60% [percent] nec [necrotic] 40% gran [granulation]..." c. 4/23/13 - sacral pressure ulcer "...Stage U... wound bed nec/slough ... " d. 4/30/13 - sacral pressure ulcer " ... Stage U ... wound bed 25% gran 75% nec ... " e. 6/18/13 - sacral pressure ulcer "...Stage IV ... " Review of the Physician telephone order dated 4/12/13 documented, "...Cleanse Rt buttock ulcer c (with) w/c [wound cleanser]. Dry. Apply skin prep to periwound. Apply Santyl & [and] Hydrogel to wound bed. Cover c dry drsg [dressing], [Change symbol] q [every] d [day] & PRN [as needed]...' Review of the Physician telephone order dated 4/24/13 documented, "...1. Rt [right] buttock ulcer now noted as sacral 2 (secondary to] increase in size... 2. D/C [discontinue] current tx [treatment] order to sacral ... " Observations in Resident #198's room on 11/5/13 Event ID:31HM11 Facility ID: TN6007 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet Page 10 of 23

PRINTED: 11/14/2013 FORM APPROVED OMB NO. 0938-0391

		AND HUMAN SERVICES				FOR	D: 11/14/2013 M APPROVED D. 0938-0391
STATEMENT	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		445118	B. WING	<u> </u>		1	1/07/2013
NAME OF F	PROVIDER OR SUPPLIER	······	·		EET ADDRESS, CITY, STATE, ZIP C		·····
ASHTON	PLACE HEALTH & R	EHAB CENTER			DWALNUT GROVE RD MPHIS, TN 38111		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	ulcer was a stage IV 2.7 cm x 0.5 cm with o'clock, with no draid During an interview 11/7/13 at 11:00 AM the weekly pressure Resident #198. Nur maroon and dark pin necrotic Order Sa wound and it was clopen wounds" During an interview 11/7/13 at 1:55 PM, Administrator (NHA (DON), and the Ass (ADON), were inform Resident #198. The unavoidable form w help with that?" The surveyor inform unavoidable pressure documentation durin did not present the chart. The NHA and and confirmed the u form was not in the to provide weekly si During an interview 11/7/13 at 3:40 PM the ADL grid docum assistants (CNA) w comatose resident.	d Resident #198's pressure /, 4.6 centimeters (cm) by (x) h undermining 3.0 at 12 inage and pink granulation. in the conference room on /, Nurse #1 was asked about e report dated 4/12/13 for se #1 stated, "It was closed, robably should not have used intyl and Hydrogel for the losed Santyl is only used for in the conference room on , the Nursing Home), the Director of Nursing med of the harm regarding e NHA stated, "the we have in the chart does not hed the NHA there was no re ulcer form in any clinical ng the chart review and staff form when they reviewed the the the Conference ulcer chart. The facility was unable kin audits as requested. at the B nurses' station on , Nurse #2, was asked what hented by the certified nursing ould reflect for turning a Nurse #2 stated, "a 4/3	F3	314			
FORM CMS-25	101al dependence w 67(02-99) Previous Versions	/ith 2 person assist"	1	Facility	y1D: TN5007 If c	ontinuation she	et Page 11 of 23

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		445118	B. WING	·····	İ	11/07/2013
	PROVIDER OR SUPPLIER	EHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP C 3030 WALNUT GROVE RD MEMPHIS, TN 38111	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD B	BE COMPLETION
F 314	During an interview 11/7/13 at 3:47 PM, documenting bathin #1 stated, "do not we turn residents w that we turn in to the We also have an as has our residents a turned we tell the when we turn them. During an interview 11/7/13 at 3:59 PM, rounds q [every] 2 h schedule, window, I turned Assignmer residents 227-2, 2 wounds not to be or done daily on side of on shower days for refuse showers mot social services and notified and everyor to see why refuses. is done by the nurse During an interview 11/7/13 at 3:59 PM, the ADL grid reflect on every shift for Re "It is very inconsis	at the B nurses' station on CNA #1 was asked about ag and turning residents. CNA do baths on 3-11 shift when e chart it on a piece of paper e nurse at the end of the shift. ssignment sheet in a book that nd when they are to be nurse and she documents " at the B nurses' station on Nurse #3 stated, "make ars and know the turning back, door, window, if pt is ht sheet has side to side 228-2, 234-1, 234-2 due to h backside Shower sheets on side Shower sheets on side Shower sheets done the other residents If they re than a day or two then the RP [responsible party] are he goes in to talk with resident A weekly skin assessment	F3	314		
F 322 SS=D	483.25(g)(2) NG TH RESTORE EATING	rehensive assessment of a	F3	 Resident #190 was asse found to be free from ha all residents that have p the facility. 	ırm as w	/ere
FORM CMS-28	567(02-99) Previous Versions		1	Facility ID: TN6007 If ca	ontinuatio	n sheet Page 12 of 23

PRINTED: 11/14/2013 FORM APPROVED OMB_NO. 0938-0391

TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G	(X3) DAT	<u>, 0938-039</u> E SURVEY IPLETED
 .		445118			11/	07/2013
	PROVIDER OR SUPPLIER	EHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 3030 WALNUT GROVE RD MEMPHIS, TN 38111	DE	·······
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 322	alone or with assist tube unless the residemonstrates that unavoidable; and (2) A resident who is gastrostomy tube re- treatment and servi- pneumonia, diarrhe- metabolic abnorma	ge 12 has been able to eat enough ance is not fed by naso gastric ident ' s clinical condition use of a naso gastric tube was s fed by a naso-gastric or eceives the appropriate ces to prevent aspiration a, vomiting, dehydration, lities, and nasal-pharyngeal e, if possible, normal eating	F 32	 All residents have the to be affected by this a deficient practice. All nurses have been in from 11-8-13 to 11-22-proper labeling of all en nutrition products by the designee. The DON of designee will monitor en nutrition products to ens appropriate labeling is in three (3) times a week f weeks then weekly for e weeks. The results of the abor observations will be refe Quality Assurance Commonthly for the next thrm months for further recor as needed. 	elleged a-serviced 13 regarding teral b DON or - - - - - - - - - - - - -	
	by: Based on medical and interview, it was to label the enteral it resident's name, da ensure it was going 2 (Resident #190) s enteral nutrition by Tube (PEG) of the 3 stage 2 review. The findings include Medical record revie documented an adr readmission date of	NT is not met as evidenced record review, observation is determined the facility failed tube feeding with the te, rate and time hung or at the prescribed rate for 1 of mampled residents receiving Percutaneous Gastrostomy 35 residents included in the ed: ew for Resident #190 mission date of 5/10/13 and a f 9/30/13 with diagnoses of etes Mellitus, Debility,				

Facility ID: TN6007

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445118 11/07/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3030 WALNUT GROVE RD ASHTON PLACE HEALTH & REHAB CENTER MEMPHIS, TN 38111 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION DATE (X4) ID 1D PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 322 Continued From page 13 F 322 Pulmonary Disease, Anemia, Asthma, Late Effect Cerebrovascular Accident and Chronic Respiratory Failure with Tracheostomy, Review of a physician's order dated 10/21/13 documented, "...increase Nutren 2.0 to 40 ml/hr (milliliter per hour] x [times] 22 hrs [hours] per PEG ... " Observations in Resident #190's room on 11/4/13 at 12:40 PM and 3:14 PM, on 11/5/13 at 8:13 AM, 10:30 AM, 2:27 PM and 4:30 PM and on 11/6/13 at 7:45 AM, 10:20 AM, 2:00 PM and 4:05 PM, revealed Resident #190 lying in bed with enteral tube feeding infusing per pump at 44 ml/hr. The bag containing the feeding was not labeled to reflect the type of feeding, the initials of the nurse that hung the feeding or the date and time the feeding was started. The feed was not going at the prescribed rate of 40 ml/hr. During an interview Resident #190's room on 11/6/13 at 10:25 AM, the Registered Dielician confirmed Resident #190's enteral tube feeding was not labeled with the type of feeding, nurse's initials or the date and time it was started. During an interview in the Administrator's office on 11/6/13 at 10:40 AM, the Director of Nursing (DON) was asked if enteral tube feeding bags should be labeled with the type of feeding and date and time it was started. The DON stated, "Yes, it should." 12/6/13 1. Resident #231 and Resident #232 F 332 F 332 483.25(m)(1) FREE OF MEDICATION ERROR were assessed and found to be free RATES OF 5% OR MORE SS=D from harm as a results of the alleged deficient practice. All remaining The facility must ensure that it is free of residents were assessed as medication error rates of five percent or greater. well and found to be free from any Event ID: 31HM91

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Facility ID: TN6007

If continuation sheet Page 14 of 23

445118		DING_			E SURVEY
	B. WING	·		11/	07/2013
NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		0//2013
ENTER		30	30 WALNUT GROVE RD EMPHIS, TN 38111		
DF DEFICIENCIES PRECEDED BY FULL FYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
t met as evidenced adical record review, t was determined the of 4 (Nurse #6) ations with a t 5 percent (%). Two de out of 26 h resulted in a 9%. hinistering ented, "Policy hall be administered in and as prescribed plementation istered in accordance R [medication ONCILIATION" policy mented, n is performed using eamwork effort from MAR are printed by I to the facility on or nonth prior to the start y staff compares the MAR's for the current new item that is not on written in by the as been DC'd as active on the new		332	 harm as a result of this allege deficient practice. 2. The alleged deficient practice potential to affect all residents facility. 3. The four LPN's that failed to follow physician orders have been in-serviced regarding the errors and have been given the policy and procedure for media administration. All involved vo an understanding of their error time and will require a follow to medication pass with the facil Development RN. An in-service provided on 11-8-13 and b ongoing thru 11-22-13 regard reconciliation of monthly orde and the importance of 24-hou chart checks. DON or designee will ensure a validate that upcoming MARS reconciled appropriately. The Development Coordinator or will perform a medication pass assessment with two (2) nurs week for four (4) weeks and perform one (1) medication past the next eight (8) weeks to er accuracy. 4. The results of the above obse will be referred to the Quality Assurance Program on a motion of the provided on the importance of the past of	has the with the with the ecation erbalize r at this up ity Staff ice will e ing rs r and are e Staff designee s es per will then ass ekly for hsure ervation	
	ONCILIATION" policy nented, is performed using earnwork effort from MAR are printed by to the facility on or nonth prior to the start staff compares the MAR's for the current new item that is not on written in by the as been DC'd as active on the new d accordingly After oted on the printed of the triplicate MAR's	ONCILIATION" policy nented, is performed using earnwork effort from MAR are printed by to the facility on or nonth prior to the start staff compares the MAR's for the current new item that is not on written in by the as been DC'd as active on the new d accordingly After oted on the printed of the triplicate MAR's	DNCILIATION" policy nented, is performed using earnwork effort from MAR are printed by to the facility on or nonth prior to the start staff compares the MAR's for the current new item that is not on written in by the as been DC'd as active on the new J accordingly After oted on the printed of the triplicate MAR's	 validate that upcoming MARS validate that upcoming MARS reconciled appropriately. The Development Coordinator or will perform a medication pass assessment with two (2) nurs week for four (4) weeks and perform one (1) medication p week for four (4) weeks and perform one (1) nurse week to the facility on or nonth prior to the start vatiff compares the MAR's for the current new item that is not on written in by the as been DC'd as active on the new d accordingly After oted on the printed of the triplicate MAR's 	 DNCILIATION" policy nented, is performed using earmwork effort from MAR are printed by to the facility on or nonth prior to the start staff compares the MAR's for the current new item that is not on written in by the as been DC'd as active on the new d accordingly After of the triplicate MAR's

Facility ID: TN6007

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	TMENT OF HEALTH							RINTED: 11. FORM APF <u>MB</u> NO: 093	ROVED
	T OF DEFICIENCIES OF CORRECTION		VSUPPLIER/CLIA ATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
(145118	B. WING				11/07/2	2013
NAME OF 1	PROVIDER OR SUPPLIER	L	······	<u> </u>	S	TREET ADDRESS, CITY, STAT	E. ZIP CODE	<u> </u>	
ASHTON	I PLACE HEALTH & F	REHAB CENT	ËR			030 WALNUT GROVE RD IEMPHIS, TN 38111			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD THE APPROPR	BE CO	(XS) MPLETION DATE		
F 332		-	- H - K.	F3	332			ļ	
	is to be separated a by the 12th of the n		to the pharmacy						
	Medical record revi documented an adu	mission date	of 10/16/13 with					i	
	diagnoses of Cereb Peripheral Arterial I Diabetes Mellitus, I	Disease, Hyp	ertension,						
	Hemorrhage. Revie 10/21/13 document [milligrams] BID [tw	ed, "Vitami	n C 500 mg						
	Zinc Sulfate 220 mg the Medication Adm	g daily X 14 c ninistration R	lays" Review of ecord (MAR)					-	
	dated 10/21/13 thro Resident #231 rece Zinc Sulfate 220 mg	eived Vitamin g for 10 days	C 500 mg and in October 2013.						1
	Review of the MAR 11/30/13 document Vitamin C 500 mg a	ed Resident	#231 received						
	days (11/1/13 throu		ale 220 mg lor 0						
	Observations in Re at 8:25 AM, Nurse a mg and Zinc Sulfate	#6 administer	red Vitamin C 500					! !	
	The physician's ord Zinc Sulfate 220 mg	er for Vitami g was written	n C 500 mg and on 10/21/13 for						:
	14 days. The order 11/4/13 doses were		stopped after the					!	
	During an interview lobby on 11/6/13 at	1:20 PM, the	e Director of						ĺ
	Nursing (DON) was MARs are accurate a specified frame a	and medica	tions are given for						
	orders. The DON s								
	During an interview 11/6/13 at 2:50 PM								
FORM CMS-2	567(02-99) Previous Versions	Obsolete	Event ID: 31HM1	1	Fac	sility ID: TN6007	If continuation	on sheet Page	16 of 23

DEPARTMENT OF HEALTH AND HUMAN SERVICES						11/14/2013 APPROVED
		& MEDICAID SERVICES			DMB NO. 0938-0391	
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		445118	B. WING		11/07/2013	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHTON	PLACE HEALTH & R	EHAB CENTER	ſ	3030 WALNUT GROVE RD MEMPHIS, TN 38111		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Prefij TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	Sulfate 220 mg for stated, "added tha have stopped on the date] should have b the MAR] nurse s MAR to the subseq be adjusted I wou indicate a stop" During an interview (RD) office on 11/6/ asked about the ord receive Vitamin C 5 mg. The RD stated. [Resident #231] ro and Juven for Vita a day for 14 days 14 days order was have started on tha the last day it should 483.35(i) FOOD PR STORE/PREPARE The facility must - (1) Procure food fro considered satisfac authorities; and (2) Store, prepare, for under sanitary cond This REQUIREMEN	Vitamin C 500 mg and Zinc Resident #231. The DON at day [10/21/13] it should e 4th [November] that [stop een reflected upon here [on hould compare the October uent MAR this MAR should Id have drawn a line to in the Registered Dietitian's '13 at 2:20 PM, the RD was fer for Resident #231 to 00 mg and Zinc Sulfate 220 ."on the 21st I saw him ecommended Vitamin C, Zinc amin C we do a protocol twice Zinc Sulfate 220 mg daily for s written for the 21st should t day Sunday [11/3/13] was d have been given" COCURE, /SERVE - SANITARY m sources approved or tory by Federal, State or local distribute and serve food	F 3	 All eight (8) residents assigned to the Restorative Dining Progra were assessed by the DON or designee and were found to be of harm as a result of the allege deficient practice. All residents involved in the Restorative Program for Nutriti potential to be affected by this a deficient practice. In-servicing was provided to CI CNA #3 and Nurse #5 regardir straws in Shasta cans by DON were instructed to pour all drink come in cans/cartons into glass cups in order to adhere to the F 	am free ed on have alleged NA #2, ig placin Staff is that is that is con	
		view, observation and		Dining policy.		

Facility ID: TN6007

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 445118 B. WING 11/07/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3030 WALNUT GROVE RD ASHTON PLACE HEALTH & REHAB CENTER MEMPHIS, TN 38111 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID. (X5) (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Additionally, all nursing and dietary F 371 Continued From page 17 F 371 staff were instructed on the proper interview, it was determined the facility failed to procedure for handwashing/hand serve meals in a sanitary manner as evidenced hygiene by the DON or designee. All by lack of hand hygiene, touching the tips of verbalized understanding of the process straws and breaking a banana in half with bare for safe food handling. hands during 2 of 2 (lunch meal on 11/4/13 and The Restorative Nurse will monitor supper meal on 11/5/13) dining observations. this process and document observations three (3) times a week for The findings included: four (4) weeks and then weekly thereafter for eight (8) weeks to ensure 1. Review of the facility's "Handwashing/Hand compliance is obtained. Hygiene" policy documented, "...Employees must 4. The results of the above observations wash their hands for at least fifteen (15) seconds will be referred to the Quality using antimicrobial or non-antimicrobial soap and Assurance Program on a monthly water under the following conditions... f. Before basis for the next three (3) months for and after eating or handling food (hand washing recommendations as needed. with soap and water)... g. Before and after assisting a resident with meals ... " 2. Observations of the lunch meal, in the dining room, on 11/4/13 at 11:40 AM, Certified Nursing assistant (CNA) #2 take a tray from the tray cart, set it on the dining table, opened a straw, touch the tip of the straw with her bare hand, then put the straw into a resident's drink without performing hand hygiene. Observations of the lunch meal, in the dining room on 11/4/13 at 11:53 AM, CNA #2 opened a straw, touched the tip of the straw with the back of her hand, then put the straw into a resident's drink without performing hand hygiene. 3. Observations of the supper meal, in the restorative dining room, on 11/5/13 at 5:00 PM. CNA #2, CNA #3, Dietary Technician #1 and Nurse #5 touched tips of straws with their bare hands while setting up dining trays. Observations in the restorative dining room on Event ID: 31HM11 Facility ID; TN6007 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet Page 18 of 23

PRINTED: 11/14/2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING B. WING 445118 11/07/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3030 WALNUT GROVE RD ASHTON PLACE HEALTH & REHAB CENTER MEMPHIS, TN 38111 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (X4) ID iD. (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 371 Continued From page 18 F 371 11/5/13 at 5:10 PM, CNA #3 washed hands with hand get cleanser then pulled chair up to the table. CNA #3 then picked up banana, peeled it, broke the banana in half with her bare hands and handed it to resident. During an interview in the conference room on 11/6/13 at 3:33 PM, the Nurse #5 was asked if the staff should touch a straw with their hands or break a banana into with their bare hands without performing hand hygiene. Nurse #5 stated, "No." F 425 1. Resident #231 and Resident #232 F 425⁺ 483.60(a).(b) PHARMACEUTICAL SVC -12/6/13 SS=D ACCURATE PROCEDURES, RPH were assessed and found to be free from harm as a result of this alleged deficient practice. The facility must provide routine and emergency 2. The alleged deficient practice has drugs and biologicals to its residents, or obtain the potential to affect all residents them under an agreement described in §483.75(h) of this part. The facility may permit within the facility. All remaining unlicensed personnel to administer drugs if State residents were assessed as well and law permits, but only under the general found to be free from any harm as a supervision of a licensed nurse. result of this alleged deficient practice. 3. The four (4) LPNs that failed to follow A facility must provide pharmaceutical services physician orders have been in-(including procedures that assure the accurate serviced by the DON or designee acquiring, receiving, dispensing, and reparding the errors and have been given the policy and procedure for administering of all drugs and biologicals) to meet the needs of each resident. medication administration. All involved verbalize an understanding The facility must employ or obtain the services of of their error at this time and will a licensed pharmacist who provides consultation require a follow-up medication pass on all aspects of the provision of pharmacy with the facility Staff Development services in the facility. Coordinator. An in-service will be provided on 11-8-13 and will be ongoing thru 11-22-13 regarding reconciliation of monthly orders and the importance of 24-hour chart check, This REQUIREMENT is not met as evidenced by: Event ID: 31HM11 Facility (D; TN6007 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet Page 19 of 23

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 445118 B. WING 11/07/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3030 WALNUT GROVE RD **ASHTON PLACE HEALTH & REHAB CENTER** MEMPHIS, TN 38111 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION in (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY F 425 i Continued From page 19 F 425 The DON or designee will ensure and Based on policy review, medical record review validate that upcoming MARS are and interview, it was determined the facility failed reconciled appropriately. The Staff to ensure prescribed medications were Development Coordinator or designee administered as ordered to meed the needs of 2 will perform a medication pass of 4 (Residents #231 and 232) residents assessment with two (2) nurses per observed during medication administration week for four (4) weeks and will then observation. perform one (1) medication pass review with one (1) nurse weekly for the The findings included: next eight (8) weeks to ensure accuracy. 1. Review of the facility's "Administering 4. The results of the above Medications" policy documented, "... Policy observations will be referred to the Statement... Medications shall be administered in Quality Assurance Program on a a safe and timely manner, and as prescribed ... monthly basis for the next three (3) Policy Interpretation and Implementation... months for further recommendations Medications must be administered in accordance as needed. with the orders ... " Review of the facility's "MAR [medication administration record) RECONCILIATION" policy per [pharmacy name] documented, "...Prescription reconciliation is performed using MAR reviews combining a teamwork effort from the the facility to pharmacy. MAR are printed by the pharmacy and delivered to the facility on or before the 25th day of the month prior to the start date on the MAR's ... Facility staff compares the printed MAR's to the actual MAR's for the current month that are in use. Any new item that is not on the printed MAR's are to be written in by the facility staff. Any item that has been DC'd [discontinued] but appears as active on the new printer MAR is to be marked accordingly... After all corrections have been noted on the printed MAR's, the pharmacy copy of the triplicate MAR's is to be separated and returned to the pharmacy by the 12th of the month ... " Medical record review for Resident #231

Event ID: 31HM11

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

PRINTED: 11/14/2013 FORM APPROVED OMB NO: 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			TE SURVEY
		445118	B. WING		11.	/07/2013
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3030 WALNUT GROVE RD MEMPHIS, TN 38111		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		IOULD BE	(X5) COMPLETION DATE
F 425	diagnoses of Ceret Peripheral Arterial I Diabetes Mellitus, I Hemorrhage. Revis 10/21/13 document [milligrams] BID [tw Zinc Sulfate 220 m Observations in Re at 8:25 AM, Nurses mg and Zinc Sulfat order for Vitamin C mg was written on order should have doses were given. During an interview (RD) office on 11/6 asked about the on receive Vitamin C 5 mg. The RD stated recommended Vita Vitamin C we do a days Zinc Sulfate order was written for started on that day last day it should h During an interview 11/6/13 at 2:50 PM (DON) was asked 500 mg and Zinc S #231. The DON sta [10/21/13] it shou [November] that reflected upon here	mission date of 10/16/13 with provascular Accident, Disease, Hypertension, Dysphagia and Subdural ew of a physician's order dated ted, "Vitamin C 500 mg vice daily] X [times] 14 days g daily X 14 days" sident #231's room on 11/6/13 #6 administered Vitamin C 500 e 220 mg. The physician's 500 mg and Zinc Sulfate 220 10/21/13 for 14 days. The stopped after the 11/4/13 v in the Registered Dietitian's /13 at 2:20 PM, the RD was der for Resident #231 to 500 mg and Zinc Sulfate 220 on the 21st I saw him min C, Zinc and Juven for protocol twice a day for 14 e 220 mg daily for 14 days or the 21st should have Sunday [11/3/13] was the ave been given" v in the conference room on l, the Director of Nursing about the order for Vitamin C sulfate 220 mg for Resident ated, "added that day uld have stopped on the 4th [stop date] should have been e [on the MAR] nurse should	F4	25		
	compare the Octob MAR this MAR s	per MAR to the subsequent hould be adjusted I would	[

Facility ID: TN6007

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:	1	E CONSTRUCTION		TE SURVEY MPLETED
		445118	B. WING			/07/2013
NAME OF F	PROVIDER OR SUPPLIEF	۲	51	REET ADDRESS, CITY, STATE, ZIP C	ODE	
ASHTON	PLACE HEALTH &	REHAB CENTER		030 WALNUT GROVE RD EMPHIS, TN 38111		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IÐ PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 425	Continued From p	ace 21	F 425			1
		to indicate a stop"				
	3. Medical record	review for Resident #232				
	÷	dmission date of 6/21/11 with a of 10/15/13 with diagnoses of	İ			
	Anxiety, Muscle V	/eakness, Anorexia,				
		pertension, Chemical Exposure Breath. Admission orders dated				i
		ed by the physician on 10/16/13				ļ
İ	documented, "F.	luconazole 100 mg tablet po [by				1
	mouth] Q [every] [ļ
ļ		R dated 10/15/13 through ted Resident #232 received				1
		ng for 7 days from 10/16/13				
	through 10/22/13.	The MAR dated 11/1/13				
	through 11/30/13		1			
	TABLET BY MOU	E 100 MG TABLET TAKE 1	-			i 1
1		." The MAR documented				
	Resident #232 rec	eived Fluconazole 100 mg daily	/			
	from 11/1/13 throu doses.	ugh 11/5/13 for a total of 5	1			
		essage from the Pharmacist				
		umented, "From	:			i
] To [facility name] DON zole Order The order was				ì
		azole 100mg take one tablet by	1			•
	mouth daily for 7 d	lays with a start date of				
	10/15/13 It shou dropped from the	Id have automatically been MAR"				
		w in the conference room on				
		M, the DON confirmed Resident				:
		loses of Fluconazole from 1/5/13 and that the pharmacy				İ
		intinued the order on the				
	November MAR.	The DON stated she had				
	spoken with Inam	ed Pharmacist] who admitted	1 1			1

		AND HUMAN SERVICES			PRINTED: 11/14/2013 FORM APPROVED OMB NO: 0938-0391
STATEMENT OF	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AN OF CORRECTION IDENT/FICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445118	B. WING		11/07/2013
NAME OF PRO	VIDER OR SUPPLIER		- l	STREET ADDRESS, CITY, STATE, ZIP CO	
ASHTON PL	ACE HEALTH & R	EHAB CENTER		3030 WALNUT GROVE RD MEMPHIS, TN 38111	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE COMPLETION
pt	ontinued From pa narmacy had mist cility.	ge 22 akenly sent the doses to the	F4	25	
:					
ORM CMS-2567((02-99) Previous Versions	Obsolete Event ID: 31HM	 11	Facility ID: TN6007 If co	ontinuation sheet Page 23 of 23

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