STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445118	A. BUILDING _____ B. WING _____	11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON PLACE HEALTH & REHAB CENTER	3030 WALNUT GROVE RD MEMPHIS, TN 38111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164 SS=D	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 contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on policy review and observation, it was determined the facility failed to maintain resident privacy for 1 of 4 (Resident #231) residents observed during medication administration. The findings included:	F 164	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, Ashton Place Rehab and Care Center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the Center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. 1. Resident #231 was assessed as well as all other residents and all found to be free of harm as a result of the alleged failed practice. 2. The alleged failed practice has the potential to affect all residents within the facility. 3. Nurse #6 was in-serviced by the DON/designee regarding privacy during medication pass administration on 11-8-13 and all other nurses received in-servicing 11-8-13 thru 11-15-13 by DON/designee. The DON/designee will ensure privacy is maintained by observations daily. The results of any concerns will be communicated to the DON or designee on a weekly basis for the next three months. 4. The results of the above observations will be referred to the Quality Assurance Program on a monthly basis for the next three (3) months for further recommendations as needed.	12/6/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: J A. Benton — TITLE: CEO/Administrator — (X6) DATE: 11-18-13

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	Continued From page 1 Review of the facility's "Administering Medications" policy documented, "...Policy Statement... Provide for privacy during medication pass, this includes pulling privacy curtains, closing doors..." Observations in Resident #231's room on 11/6/13 at 8:25 AM, Nurse #6 administered Resident #231's medications through the Percutaneous Endoscopy Gastrostomy Tube without closing the door and providing full visual privacy.	F 164		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure the five residents seated at the restorative dining table were treated with dignity during 2 of 2 (lunch on 11/4/13 and supper on 11/5/13) fine dining observations. The findings included: 1. Review of the facility's "Fine Dining Program Guidelines" policy documented, "...Purpose: To promote quality of life by encouraging independence and dignity in a home-like environment utilizing Fine Dining equipment and supplies..."	F 241	1. All eight (8) residents assigned to the Restorative Dining program were assessed by the DON or designee and were found to be free of harm as a result of the alleged failed practice. 2. All residents have the potential to be harmed by this alleged deficient practice. 3. In-servicing was provided to CNA #2 and #3 regarding placing straws in Shasta cans. This in-servicing was also provided to Nurse #5. Staff were instructed to pour all drinks that come in cans/cartons into glasses in order to adhere to the fine dining policy. All verbalize understanding of the process. The restorative nurse will monitor this process and document observations three (3) times a week for four (4) weeks and then weekly thereafter for eight (8) weeks to ensure compliance is obtained.	12/6/13

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F 241	Continued From page 2 2. Observations in the main dining room on 11/4/13 at 11:45 AM, revealed 5 residents seated at the restorative dining table. Certified Nursing Assistant (CNA) #2 placed a straw in all 5 residents' cans of shasta cola. At 12:00 PM, kitchen staff poured shasta cola into glasses for the residents in the main dining room but not for the residents seated ate the restorative dining table. 3. Observations in the restorative dining room on 11/5/13 at 5:00 PM, CNA #3 placed a straw in a shasta cola can for a resident at the restorative dining table. 4. During an interview in the Dietary Manager's (DM) office on 11/6/13 at 9:35 AM, the DM was asked if there was a reason the residents at the restorative table were served their cola in cans while the other residents had their cola in a glass. The DM stated, "No, we put an extra cup and a straw for each drink on their tray..." During an interview in the conference room on 11/6/13 at 3:33 PM, Nurse #5 was asked why the residents at the restorative table did not have their colas poured into a glass or cup. Nurse #5 stated, "I never thought about it."	F 241	4. The results of the above observations will be referred to the Quality Assurance Program on a monthly basis for the next three (3) months for further recommendations as needed.	
F 309 SS=D	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.	F 309	1. Resident #231 and Resident #232 were assessed and found to be free from harm as a result of the alleged deficient practice. 2. The alleged deficient practice has the potential to affect all residents within the facility. All remaining residents were assessed as well and found to be	12/6/13

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F 309	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, it was determined the facility failed to follow physician's orders for medication administration for 2 of 4 (Residents #231 and 232) residents observed during medication administration. The findings included: 1. Review of the facility's "Administering Medications" policy documented, "...Policy Statement... Medications shall be administered in a safe and timely manner, and as prescribed... Policy Interpretation and Implementation... Medications must be administered in accordance with the orders..." 2. Medical record review for Resident #231 documented an admission date of 10/16/13 with diagnoses of Cerebrovascular Accident, Peripheral Arterial Disease, Hypertension, Diabetes Mellitus, Dysphagia and Subdural Hemorrhage. Review of a physician's order dated 10/21/13 documented, "...Vitamin C 500 mg [milligrams] BID [twice daily] X [times] 14 days... Zinc Sulfate 220 mg daily X 14 days..." Review of the Medication Administration Record (MAR) dated 10/21/13 through 10/31/13 documented Resident #231 received Vitamin C 500 mg and Zinc Sulfate 220 mg for 10 days in October 2013. Review of the MAR dated 11/1/13 through 11/30/13 documented Resident #231 received Vitamin C 500 mg and Zinc Sulfate 220 mg for 6 days (11/1/13 through 11/6/13).	F 309	free from any harm as a result of this alleged deficient practice. 3. The four LPN's that failed to completely follow physician orders have been in-serviced regarding the errors and have been given the policy and procedure for medication administration. All involved verbalize an understanding of their error at this time and will require a follow up medication pass with the facility Staff Development RN. An in-service will 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 ensure and validate that upcoming MARS are reconciled appropriately. The Staff Development Coordinator or designee will perform a medication pass assessment with two (2) nurses per week for four (4) weeks and will then perform one (1) medication pass review with one (1) nurse weekly for the next eight (8) weeks to ensure accuracy. 4. The results of the above observation will be referred to the Quality Assurance Program on a monthly basis for the next three (3) months for further recommendations as needed.	

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F 309	Continued From page 4 Observations in Resident #231's room on 11/6/13 at 8:25 AM, Nurse #6 administered Vitamin C 500 mg and Zinc Sulfate 220 mg to Resident #231. The physician's order for Vitamin C 500 mg and Zinc Sulfate 220 mg was written on 10/21/13 for 14 days. The order should have stopped after the 11/4/13 doses were given. During an interview in the conference room on 11/6/13 at 2:50 PM, the Director of Nursing (DON) was asked about the order for Vitamin C 500 mg and Zinc Sulfate 220 mg for Resident #231. The DON stated, "...added that day [10/21/13]... it should have stopped on the 4th [November]... that [stop date] should have been reflected upon here [on the MAR]... nurse should compare the October MAR to the subsequent MAR... this MAR should be adjusted... I would have drawn a line to indicate a stop..." During an interview in the Registered Dietitian's (RD) office on 11/6/13 at 2:20 PM, the RD was asked about the order for Resident #231 to receive Vitamin C 500 mg and Zinc Sulfate 220 mg. The RD stated. "...on the 21st I saw him [Resident #231]... recommended Vitamin C, Zinc and Juven... for Vitamin C we do a protocol twice a day for 14 days... Zinc Sulfate 220 mg daily for 14 days... order was written for the 21st... should have started on that day... Sunday [11/3/13] was the last day it should have been given..." 3. Medical record review for Resident #232 documented an admission date of 6/21/11 with a readmission date of 10/15/13 with diagnoses of Anxiety, Muscle Weakness, Osteoarthritis, Hypertension, Anorexia, Chemical Exposure and Shortness of Breath. Review of the admission	F 309		

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F 309	Continued From page 5 orders dated 10/15/13 and signed by the physician on 10/16/13 documented, "...Fluconazole 100 mg tablet po [by mouth] Q [every] Day X 7 days..." Review of the MAR dated 10/15/13 through 10/31/13 documented Resident #232 received Fluconazole 100 mg for 7 days from 10/16/13 through 10/22/13. The MAR dated 11/1/13 through 11/30/13 documented, "...FLUCONAZOLE 100 MG TABLET... TAKE 1 TABLET BY MOUTH ONCE DAILY (ANTI-FUNGAL)..." The MAR documented Resident #232 received Fluconazole 100 mg daily from 11/1/13 through 11/5/13 for a total of 5 doses. Review of a fax message from the Pharmacist dated 11/6/13 documented, "...From... [Pharmacist name]... To... [facility name] DON... Subject... Fluconazole Order... The order was written as Fluconazole 100mg take one tablet by mouth daily for 7 days with a start date of 10/15/13.. .It should have automatically been dropped from the MAR..." During an interview in the conference room on 11/6/13 at 1:35 PM, the DON confirmed Resident #232 received 5 doses of Fluconazole from 11/1/13 through 11/5/13 and the pharmacy had mistakenly continued the order on the November MAR. The DON stated she had spoken with [named Pharmacist] who admitted pharmacy had mistakenly sent the doses to the facility. 4. During an interview in the second floor tower lobby on 11/6/13 at 1:20 PM, the DON was asked about making sure the MARs are accurate and medications are given for a specified frame according to the physician's orders. The DON stated, "...it's my staff's responsibility..."	F 309		

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F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on review of the "National Pressure Advisory Panel [NPUAP] Pressure Ulcer Prevention" quick reference guide, policy review, medical record review, observation and interview, it was determined the facility failed to identify a pressure ulcer before it became unstageable with necrosis for 1 of 6 (Resident #198) sampled residents reviewed of the 6 residents with pressure ulcers. The failure to identify a pressure ulcer before it became unstageable with necrosis resulted in an actual harm for Resident #198. The findings included: Review of the NAPUAP Pressure Ulcer Prevention quick reference guide documented, "[page] 9... Unstageable / Unclassified: Full thickness skin or tissue loss-depth unknown Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown, black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be	F 314	1. All residents have the potential to be affected by this alleged deficient practice. Resident #198 had already been identified by the facility as having an facility acquired pressure and has been receiving treatment since 4-12-13. The wound continues to show improvement at this time. 2. All other residents within the facility received a head-to-toe body audit by facility treatment nurses. No other areas of concern have been identified. 3. The facility has re-educated all clinical staff on the facility turning and repositioning schedule every two hours. A copy of this schedule has been placed on the MAR as well as the CNA care guide. A turn and reposition form has also been created and will be utilized by clinical staff showing documentation of such. The facility has revised the weekly nurses skin assessment audit to ensure appropriate assessments are completed as required. The nurses will be in-serviced on this skin assessment audits from 11-8-13 to 11-15-13 by DON or designee. The Unit Managers will review these audits completed in Clinical meetings Monday-Friday for completion. 4. The results of the above observations will be referred to the Quality Assurance Program for the next three (3) months for further recommendations as needed.	12/6/13

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F 314	Continued From page 7 determined; but it will be either a Category/Stage III [3] or IV [4]... [page] 12... 3. Inspect skin regularly for signs of redness... Ongoing assessment of the skin is necessary to detect early signs of pressure damage. 4. Skin inspection should include assessment for localized heat, edema, or induration (hardness), especially in individuals with darkly pigmented skin... [page] 13... 6. Observe the skin for pressure damage caused by medical devices... Many different types of medical devices have been reported as having caused pressure damage... 7. Document all skin assessments, noting details of any pain possibly related to pressure damage..." Review of the NAPUAP Pressure Ulcer Prevention quick reference guide documented, "[page] 11... 6. Use a structured approach to risk assessment that includes a comprehensive skin assessment to evaluate any alterations to intact skin... 10. Conduct a structured risk assessment on admission, and repeat as regularly and as frequently as required by the individual's condition... [page] 12... 1. Ensure that a complete skin assessment is part of the risk assessment screening policy in place in all health care settings... 3. Inspect skin regularly for signs of redness in individuals identified as being at risk of pressure ulceration. The frequency of inspection may need to be increased in response to any deterioration in overall condition... Ongoing assessment of the skin is necessary to detect early signs of pressure damage. Review of the facility's "Repositioning" policy documented, "...The following information should be recorded in the resident's medical record... any change in the resident's condition..."	F 314		

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F 314	Continued From page 8 Review of the facility's "Shower/Tub Bath" policy documented, "...Observe the resident's skin for any redness, rashes, broken skin, tender places, irritation, reddish or blue-gray area of skin over a pressure point, blisters, or skin breakdown... The following information should be recorded on the resident's ADL [activities of daily living] record and/or in the resident's medical record... All assessment data (...any reddened areas, sores... on the resident's skin) obtained during the shower/tub bath... Notify the physician of any skin areas that may need to be treated..." Medical record review for Resident #198 documented an admission date of 1/28/13 and with diagnoses of Hemiplegia, Dysphagia, Mental Disorder, Aphasia, Gastrostomy, Lack of Coordination, Congestive Heart Failure, Cardiomyopathy, Debility, Hypertension, Hyperlipidemia, Osteoporosis, Oliguria and Anuria, Anemia, Urinary Retention. Review of an annual Minimum Data Set (MDS) dated 2/4/13 documented Resident #198 was at risk to develop pressure ulcers and section G documented resident is totally dependent on staff for positioning and all ADLs. Review of the quarterly MDS dated 10/28/13 documented one stage 4 sacral pressure ulcer. Review of the care plan dated 2/8/13 documented, "...Potential for skin breakdown... Approaches... Monitor skin daily... full body audit weekly... skin risk assessment quarterly..." Review of the fixed care plan dated 4/12/13 documented, "...Actual Alteration in skin integrity: Pressure Ulcer related to Stage SDTI [Suspected Deep Tissue Injury] Rt [right] buttock... Approaches... Pressure ulcer risk assessment	F 314		

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F 314	Continued From page 9 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	F 314		

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F 314	Continued From page 10 at 2:25 PM, revealed Resident #198's pressure ulcer was a stage IV, 4.6 centimeters (cm) by (x) 2.7 cm x 0.5 cm with undermining 3.0 at 12 o'clock, with no drainage and pink granulation. During an interview in the conference room on 11/7/13 at 11:00 AM, Nurse #1 was asked about the weekly pressure report dated 4/12/13 for Resident #198. Nurse #1 stated, "...It was closed, maroon and dark probably should not have used necrotic... Order Santyl and Hydrogel for the wound and it was closed... Santyl is only used for open wounds..." During an interview in the conference room on 11/7/13 at 1:55 PM, the Nursing Home Administrator (NHA), the Director of Nursing (DON), and the Assistant Director of Nursing (ADON), were informed of the harm regarding Resident #198. The NHA stated, "...the unavoidable form we have in the chart does not help with that?..." The surveyor informed the NHA there was no unavoidable pressure ulcer form in any clinical documentation during the chart review and staff did not present the form when they reviewed the chart. The NHA and the DON reviewed the chart and confirmed the unavoidable pressure ulcer form was not in the chart. The facility was unable to provide weekly skin audits as requested. During an interview at the B nurses' station on 11/7/13 at 3:40 PM, Nurse #2, was asked what the ADL grid documented by the certified nursing assistants (CNA) would reflect for turning a comatose resident. Nurse #2 stated, "...a 4/3... total dependence with 2 person assist..."	F 314		

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F 314	Continued From page 11 During an interview at the B nurses' station on 11/7/13 at 3:47 PM, CNA #1 was asked about documenting bathing and turning residents. CNA #1 stated, "...do not do baths on 3-11 shift... when we turn residents we chart it on a piece of paper that we turn in to the nurse at the end of the shift. We also have an assignment sheet in a book that has our residents and when they are to be turned... we tell the nurse and she documents when we turn them..." During an interview at the B nurses' station on 11/7/13 at 3:59 PM, Nurse #3 stated, "...make rounds q [every] 2 hrs and know the turning schedule, window, back, door, window, if pt is turned... Assignment sheet has side to side... residents... 227-2, 228-2, 234-1, 234-2 due to wounds not to be on backside... Shower sheets done daily on side on side... Shower sheets done on shower days for the other residents... If they refuse showers more than a day or two then social services and the RP [responsible party] are notified and everyone goes in to talk with resident to see why refuses... A weekly skin assessment is done by the nurse on everyone..." During an interview at the B nurses' station on 11/7/13 at 3:59 PM, Nurse #4 was asked about the ADL grid reflecting bathing being performed on every shift for Resident #198. Nurse #4 stated, "...It is very inconsistent... No, I do not believe residents are being bathed every shift... it is very inconsistent..."	F 314		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that --	F 322	1. Resident #190 was assessed and found to be free from harm as were all residents that have peg tubes in the facility.	12/6/13

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F 322	Continued From page 12 (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, it was determined the facility failed to label the enteral tube feeding with the resident's name, date, rate and time hung or ensure it was going at the prescribed rate for 1 of 2 (Resident #190) sampled residents receiving enteral nutrition by Percutaneous Gastrostomy Tube (PEG) of the 35 residents included in the stage 2 review. The findings included: Medical record review for Resident #190 documented an admission date of 5/10/13 and a readmission date of 9/30/13 with diagnoses of Hypertension, Diabetes Mellitus, Debility, Dysphagia with PEG, Chronic Obstructive	F 322	2. All residents have the potential to be affected by this alleged deficient practice. 3. All nurses have been in-serviced from 11-8-13 to 11-22-13 regarding proper labeling of all enteral nutrition products by the DON or designee. The DON or designee will monitor enteral nutrition products to ensure appropriate labeling is in place three (3) times a week for four (4) weeks then weekly for eight (8) weeks. 4. The results of the above observations will be referred to the Quality Assurance Committee monthly for the next three (3) months for further recommendations as needed.	

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F 322	Continued From page 13 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 Dietician 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."	F 322		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332	1. Resident #231 and Resident #232 were assessed and found to be free from harm as a results of the alleged deficient practice. All remaining residents were assessed as well and found to be free from any	12/6/13

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F 332	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure by 1 of 4 (Nurse #6) nurses administered medications with a medication error of less that 5 percent (%). Two medication errors were made out of 26 opportunities for error, which resulted in a medication error rate of 7.69%. The findings included: Review of the facility's "Administering Medications" policy documented, "...Policy Statement... Medications shall be administered in a safe and timely manner, and as prescribed... Policy Interpretation and Implementation... Medications must be administered in accordance 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	F 332	harm as a result of this alleged deficient practice. 2. The alleged deficient practice has the potential to affect all residents with the 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 medication administration. All involved verbalize an understanding of their error at this time and will require a follow up medication pass with the facility Staff Development RN. An in-service will 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. DON or designee will ensure and validate that upcoming MARS are reconciled appropriately. The Staff Development Coordinator or designee will perform a medication pass assessment with two (2) nurses per week for four (4) weeks and will then perform one (1) medication pass review with one (1) nurse weekly for the next eight (8) weeks to ensure accuracy. 4. The results of the above observation will be referred to the Quality Assurance Program on a monthly basis for the next three (3) months for further recommendations as needed.	

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F 332	Continued From page 15 is to be separated and returned to the pharmacy by the 12th of the month..." Medical record review for Resident #231 documented an admission date of 10/16/13 with diagnoses of Cerebrovascular Accident, Peripheral Arterial Disease, Hypertension, Diabetes Mellitus, Dysphagia and Subdural Hemorrhage. Review of a physician's order dated 10/21/13 documented, "...Vitamin C 500 mg [milligrams] BID [twice daily] X [times] 14 days... Zinc Sulfate 220 mg daily X 14 days..." Review of the Medication Administration Record (MAR) dated 10/21/13 through 10/31/13 documented Resident #231 received Vitamin C 500 mg and Zinc Sulfate 220 mg for 10 days in October 2013. Review of the MAR dated 11/1/13 through 11/30/13 documented Resident #231 received Vitamin C 500 mg and Zinc Sulfate 220 mg for 6 days (11/1/13 through 11/6/13). Observations in Resident #231's room on 11/6/13 at 8:25 AM, Nurse #6 administered Vitamin C 500 mg and Zinc Sulfate 220 mg to Resident #231. The physician's order for Vitamin C 500 mg and Zinc Sulfate 220 mg was written on 10/21/13 for 14 days. The order should have stopped after the 11/4/13 doses were given. During an interview in the second floor tower lobby on 11/6/13 at 1:20 PM, the Director of Nursing (DON) was asked about making sure the MARs are accurate and medications are given for a specified frame according to the physician's orders. The DON stated, "...it's my staff's responsibility..." During an interview in the conference room on 11/6/13 at 2:50 PM, the the DON was asked	F 332		

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F 332	Continued From page 16 about the order for Vitamin C 500 mg and Zinc Sulfate 220 mg for Resident #231. The DON stated, "...added that day [10/21/13]... it should have stopped on the 4th [November]... that [stop date] should have been reflected upon here [on the MAR]... nurse should compare the October MAR to the subsequent MAR... this MAR should be adjusted... I would have drawn a line to indicate a stop..." During an interview in the Registered Dietitian's (RD) office on 11/6/13 at 2:20 PM, the RD was asked about the order for Resident #231 to receive Vitamin C 500 mg and Zinc Sulfate 220 mg. The RD stated. "...on the 21st I saw him [Resident #231]... recommended Vitamin C, Zinc and Juven... for Vitamin C we do a protocol twice a day for 14 days... Zinc Sulfate 220 mg daily for 14 days... order was written for the 21st... should have started on that day... Sunday [11/3/13] was the last day it should have been given..."	F 332		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on policy review, observation and	F 371	1. All eight (8) residents assigned to the Restorative Dining Program were assessed by the DON or designee and were found to be free of harm as a result of the alleged deficient practice. 2. All residents involved in the Restorative Program for Nutrition have potential to be affected by this alleged deficient practice. 3. In-servicing was provided to CNA #2, CNA #3 and Nurse #5 regarding placing straws in Shasta cans by DON. Staff were instructed to pour all drinks that come in cans/cartons into glasses or cups in order to adhere to the Fine Dining policy.	12/6/13

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F 371	Continued From page 17 interview, it was determined the facility failed to serve meals in a sanitary manner as evidenced by lack of hand hygiene, touching the tips of straws and breaking a banana in half with bare hands during 2 of 2 (lunch meal on 11/4/13 and supper meal on 11/5/13) dining observations. The findings included: 1. Review of the facility's "Handwashing/Hand Hygiene" policy documented, "...Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions... f. Before and after eating or handling food (hand washing 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	F 371	Additionally, all nursing and dietary staff were instructed on the proper procedure for handwashing/hand hygiene by the DON or designee. All verbalized understanding of the process for safe food handling. The Restorative Nurse will monitor this process and document observations three (3) times a week for four (4) weeks and then weekly thereafter for eight (8) weeks to ensure compliance is obtained. 4. The results of the above observations will be referred to the Quality Assurance Program on a monthly basis for the next three (3) months for recommendations as needed.	

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F 371	Continued From page 18 11/5/13 at 5:10 PM, CNA #3 washed hands with hand gel 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. 4. 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 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by:	F 425	1. Resident #231 and Resident #232 were assessed and found to be free from harm as a result of this alleged deficient practice. 2. The alleged deficient practice has the potential to affect all residents within the facility. All remaining residents were assessed as well and found to be free from any harm as a result of this alleged deficient practice. 3. The four (4) LPNs that failed to follow physician orders have been in-serviced by the DON or designee regarding the errors and have been given the policy and procedure for medication administration. All involved verbalize an understanding of their error at this time and will require a follow-up medication pass with the facility Staff Development 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.	12/6/13

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F 425	Continued From page 19 Based on policy review, medical record review and interview, it was determined the facility failed to ensure prescribed medications were administered as ordered to meed the needs of 2 of 4 (Residents #231 and 232) residents observed during medication administration observation. The findings included: 1. Review of the facility's "Administering Medications" policy documented, "...Policy Statement... Medications shall be administered in a safe and timely manner, and as prescribed... Policy Interpretation and Implementation... Medications must be administered in accordance 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..." 2. Medical record review for Resident #231	F 425	The DON or designee will ensure and validate that upcoming MARS are reconciled appropriately. The Staff Development Coordinator or designee will perform a medication pass assessment with two (2) nurses per week for four (4) weeks and will then perform one (1) medication pass review with one (1) nurse weekly for the next eight (8) weeks to ensure accuracy. 4. The results of the above observations will be referred to the Quality Assurance Program on a monthly basis for the next three (3) months for further recommendations as needed.	

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F 425	Continued From page 20 documented an admission date of 10/16/13 with diagnoses of Cerebrovascular Accident, Peripheral Arterial Disease, Hypertension, Diabetes Mellitus, Dysphagia and Subdural Hemorrhage. Review of a physician's order dated 10/21/13 documented, "...Vitamin C 500 mg [milligrams] BID [twice daily] X [times] 14 days... Zinc Sulfate 220 mg daily X 14 days..." Observations in Resident #231's room on 11/6/13 at 8:25 AM, Nurse #6 administered Vitamin C 500 mg and Zinc Sulfate 220 mg. The physician's order for Vitamin C 500 mg and Zinc Sulfate 220 mg was written on 10/21/13 for 14 days. The order should have stopped after the 11/4/13 doses were given. During an interview in the Registered Dietitian's (RD) office on 11/6/13 at 2:20 PM, the RD was asked about the order for Resident #231 to receive Vitamin C 500 mg and Zinc Sulfate 220 mg. The RD stated. "...on the 21st I saw him... recommended Vitamin C, Zinc and Juven... for Vitamin C we do a protocol twice a day for 14 days... Zinc Sulfate 220 mg daily for 14 days... order was written for the 21st... should have started on that day... Sunday [11/3/13] was the last day it should have been given..." During an interview in the conference room on 11/6/13 at 2:50 PM, the Director of Nursing (DON) was asked about the order for Vitamin C 500 mg and Zinc Sulfate 220 mg for Resident #231. The DON stated, "...added that day [10/21/13]... it should have stopped on the 4th [November]... that [stop date] should have been reflected upon here [on the MAR]... nurse should compare the October MAR to the subsequent MAR... this MAR should be adjusted... I would	F 425		

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F 425	Continued From page 21 have drawn a line to indicate a stop..." 3. Medical record review for Resident #232 documented an admission date of 6/21/11 with a readmission date of 10/15/13 with diagnoses of Anxiety, Muscle Weakness, Anorexia, Osteoarthritis, Hypertension, Chemical Exposure and Shortness of Breath. Admission orders dated 10/15/13 and signed by the physician on 10/16/13 documented, "...Fluconazole 100 mg tablet po [by mouth] Q [every] Day X 7 days..." Review of the MAR dated 10/15/13 through 10/31/13 documented Resident #232 received Fluconazole 100 mg for 7 days from 10/16/13 through 10/22/13. The MAR dated 11/1/13 through 11/30/13 documented, "...FLUCONAZOLE 100 MG TABLET... TAKE 1 TABLET BY MOUTH ONCE DAILY (ANTI-FUNGAL)..." The MAR documented Resident #232 received Fluconazole 100 mg daily from 11/1/13 through 11/5/13 for a total of 5 doses. Review of a fax message from the Pharmacist dated 11/6/13 documented, "...From... [pharmacist name]... To... [facility name] DON... Subject... Fluconazole Order... The order was written as Fluconazole 100mg take one tablet by mouth daily for 7 days with a start date of 10/15/13... It should have automatically been dropped from the MAR..." During an interview in the conference room on 11/6/13 at 1:35 PM, the DON confirmed Resident #232 received 5 doses of Fluconazole from 11/1/13 through 11/5/13 and that the pharmacy had mistakenly continued the order on the November MAR. The DON stated she had spoken with [named Pharmacist] who admitted	F 425		

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F 425	Continued From page 22 pharmacy had mistakenly sent the doses to the facility.	F 425		