The facilities medication error rate will be less than 5%. The facility will administer medications using accepted professional standards and will continue to ensure that residents are free of significant medication errors. The facility will continue to provide education and materials that aid in reducing the potential for medication errors.

1. Upon being informed of the stated errors, the listed resident’s medication administration records were reviewed, their physician was notified, and the residents were assessed for and noted to have no adverse medication consequences. The DON completed one on one interview with nurse #2 and #1 addressing the specific errors, administering medications at the correct time, administering the correct medication dosage, and the correct amount of time needed to wait between puffs for inhaled medication.

On 06/15/2011 Healthcare pharmacy consultant will observe nurse #2 medication pass. The DON or designee will observe medication passes with nurse #1 and #2 during their next medication pass and randomly until their medication pass is without errors.
<table>
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<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER/S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
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<tbody>
<tr>
<td>F 332</td>
<td>Continued From page 1</td>
<td>Observations in Resident #9's room on 6/1/11 at 7:22 AM, Nurse #2 administered 20 milligrams (mg) of Famotidine to Resident #8. The Famotidine was to be administered at HS. The administration of the Famotidine at this time resulted in medication error #1. During an interview at the A wing nurses' station on 6/1/11 at 6:45 PM, Nurse #2 confirmed that the 20 mgs of Famotidine should not have been given until bedtime. 3. Medical record review for Random Resident (RR) #1 documented an admission date of 5/11/11 with diagnoses of Hypertension, Osteoporosis, Fractured Ischium, Fractured Pubis and Fractured Humerus. Review of a physician's order dated 5/31/11 documented, &quot;...DC (discontinue) Lortab 5/325 mg II [two] po [by mouth] q [every] 4 hours for pain. Give Lortab 5/325 mg II po q 6 hours for pain...&quot; Observations in RR #1's room on 5/29/11 at 6:20 PM, Nurse #1 administered one tablet of Lortab 5/325 mg to RR #1. The failure to administer two tablets of Lortab 5/325 mg as ordered by the physician resulted in medication error #2. 4. Review of the facility's &quot;Administering Medications through a Metered Dose Inhaler&quot; documented, &quot;... Allow at least one (1) minute between inhalations of the same medication and at least two (2) minutes between inhalations of different medications.&quot; Medical record review for RR #2 documented an admission date of 5/6/11 with diagnoses of Pleural Effusion, Chest Pain and Atrial Fibrillation.</td>
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| | | | | 6/7/11 |
| 2. | The DON reviewed the survey deficiencies with the nursing staff. Medication administration in-service was conducted by the facility's QA nurse on 06/07/2011 for licensed nurses. Medication error deficiencies were included in the in-service. |

| | | | | 6/10/11 |
| 3. | The DON or designee will observe medication pass audits with random licensed nurses over the next 30 days until satisfactory performance is maintained. On 06/14/2011, Healthcare pharmacy services will conduct a medication administration in-service for licensed nurses. Medication administration in-service will be completed monthly times three months by the QA nurse or designee beginning with 06/14/2011 in-service. |

<p>| | | | | 6/14/11 |
| 4. | The DON, or designee will review medication pass audits for noted issues, areas of improvement, and educational needs monthly times three months and then with quarterly QA. The facility policy will be followed for managing and investigating medication errors. Exceptions will be addressed and brought to the QA committee for resolution. |</p>
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<tr>
<th>ID</th>
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| F 332 | Continued From page 2
Review of a physician's order dated 5/17/11 documented, "...Spiriva 18 mcg [micrograms] ii inhalations daily...
Observations in RR #2's room on 6/1/11 at 7:41 AM, Nurse #2 administered 2 inhalations of a Spiriva inhaler to RR #2. Nurse #2 did not pause for at least one minute between the inhalations. The failure to pause at least one minute between inhalations resulted in medication error #3.
During an interview at the A wing nurse's station on 6/1/11 at 6:45 PM, Nurse #2 confirmed that she did not wait for at least one minute between puffs.
5. During an interview in the board room on 6/2/11 at 7:18 AM, the Director of Nursing confirmed that nurses were to check the medications against the Medication Administration Record (MAR) to ensure they matched, to give the correct dosage and that nurses had a guide in front of the MAR to refer to minutes to wait between puffs of an inhaler. |
| F 441 | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS
The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.
(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility; |
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER: THE MEADOWS

STREET ADDRESS, CITY, STATE, ZIP CODE: 6044 COLEY DAVIS ROAD, NASHVILLE, TN 37221

(S) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 445496

(S) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(S) DATE SURVEY COMPLETED: 06/02/2011

(S) ID PREFIX TAG

<table>
<thead>
<tr>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<tr>
<td>EACH DEFICIENCY MUST BE PRECEDED BY FULL</td>
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<tr>
<td>REGULATORY OR LSC IDENTIFYING INFORMATION</td>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>EACH CORRECTIVE ACTION SHOULD BE</td>
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<td>CROSS-REFERENCED TO THE APPROPRIATE</td>
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<td>DEFICIENCY</td>
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<th>(K) COMPLETION DATE</th>
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F 441 Continued From page 3

(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food. If direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

This requirement is not met as evidenced by:

Based on policy review, observation and interview, it was determined the facility failed to ensure practices to prevent the potential spread of infection were maintained by 2 of 4 nurses (Nurses #1 and 2) when they failed to wash their hands with soap and turned the faucet off with their bare hands during medication administration; when 2 of 2 Certified Nursing Assistants (CNA #1 and 2) placed used trays back on the cart with trays of food that had not been properly washed.

F 441
The facility will maintain and monitor an infection control program designed to provide a safe, sanitary and comfortable environment which aids in the prevention and transmission of infection. The facility will ensure practices to prevent the potential spread of infection and the facility's infection control program will continue to provide staff education regarding preventing the spread of infection including hand washing technique.

1. Upon being informed of the staff members failing to use the correct procedure for hand washing the quality assurance nurse completed one on one in-service regarding correct hand washing procedure and hand washing skills checkoffs with nurse #2, #1 and C.N.A. #1 on 06/07/2011. The DON reviewed the deficient practice with these employees. The DON or designee will re-observe nurse #2, #1 and C.N.A. #1 hand washing skills randomly over the next 30 days and then as needed until no errors are noted with their hand-washing skills.

6/7/11
F 441 Continued From page 4

been served yet during dining observations and
CNA #1 failed to wash his contaminated hands
with soap and water after assisting with a
dressing change.

The findings included:

1. Review of the facility’s "Handwashing/Hand
Hygiene" policy documented, "...5. Must wash
their hands for ten (10) to fifteen (15) seconds
using antimicrobial or non-antimicrobial soap and
water under the following conditions: a. Before
and after direct contact with residents; b. After
removing gloves...6. In most situations, the
preferred method of hand hygiene is with an
alcohol-based hand rub...d. Before preparing or
handling medications..."

2. Observations in Random Resident (RR) #1’s
room on 5/31/11 at 6:20 PM, Nurse #1 turned off
the water with her bare hands after handwashing.

Observations in Resident #8’s room on 6/1/11 at
7:22 AM, RR #2’s room on 6/1/11 at 7:41 AM and
Resident #3’s room on 6/1/11 at 8:03 AM, Nurse
#2 did not wash her hands with soap, she just
rinsed her hands, and turned off the water with
her bare hands.

Observations in RR #2’s room on 6/1/11 at 11:00
AM, Resident #3’s room on 6/1/11 at 10:05 AM
and RR #1’s room on 6/1/11 at 12:00 PM,
revealed Nurse #2 turned off the water with her
bare hands after handwashing.

Observations in RR #4’s room on 6/1/11 at 4:05
PM and RR #1’s room on 6/1/11 at 6:02 PM,
Nurse #2 turned off the water with her bare hands.
Continued From page 5 after handwashing.

During an interview in the A wing nurses station on 6/1/11 at 7:41 AM, Nurse #2 stated, "...I know I didn't use soap every time and I didn't use paper towel [to turn faucet off]."

During an interview in the board room on 6/2/11 at 7:18 AM, the Director of Nursing (DON) stated, "...turn on water, soap, rinse and turn the water off..."

3. Observations in A wing hallway on 5/31/11 at 5:30 PM, CNA #2 set the meal tray on the resident's overbed table, set items off the tray onto the overbed table and returned the meal tray to the cart containing meal trays that had not been served.

Observations in A wing hallway on 6/1/11 at 11:27 AM, revealed CNA #1 set up the meal tray on the resident's overbed table and returned the meal tray to the food cart containing meat trays that had not yet been served.

During an interview in the board room on 6/2/11 at 7:29 AM, the DON confirmed that dirty trays should not be placed on the meal cart containing clean, unserved meal trays.

4. Observations in Resident #3's room on 6/1/11 at 9:08 AM revealed CNA #1 assisted Nurse #4 during dressing change. CNA #1 donned gloves. Nurse #4 asked CNA #1 to close the window blind. CNA #1 removed the gloves, washed his hands, turned off the faucet with his bare hands, then dried his hands. When Resident #3 was positioned on his left side, CNA #1 removed the
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<td>Continued From page 6 adult diaper with gloved hands, cleaned Resident #3's buttocks with disposable gloves. CNA #1 removed his gloves, went into the bathroom and ran water over his hands and dried with a paper towel. During an interview in the A wing hallway on 6/2/11 at 7:18 AM, Nurse #4 verified CNA #1 did not wash his hands using soap...</td>
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