STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445033	A. BUILDING _____ B. WING _____	**03/31/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NASHVILLE COMMUNITY CARE & REHABILITATION AT BORDE	**1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, medical record review, and interview the facility failed to prevent a significant medication error for 1 resident (Resident #2) of 3 residents reviewed. The findings include: Review of the facility policy Medication Administration General Guidelines dated 9/18 revealed .prior administrator, review, and confirm medication orders. Continued review of the facility policy Medication Discrepancies revised 11/16/19 revealed .discrepancies are documented and reported to the resident's attending physician, Director of Nursing, responsible party and the Performance Improvement Committee.in the event of a medication discrepancy immediate action is taken.to protect the patient.the attending Physician is notified.the Physician's orders are implemented.the resident is monitored closely for 24 to 72 hours.reports are reviewed on a regular basis by the performance Improvement Committee. Further review of facility policy Medication Error Reporting and Adverse Drug Reaction Prevention and Detection dated 9/10 revealed .the facility utilizes a system to assure that medication usage is evaluated on an ongoing basis.medication errors.are considered significant if.require.modifying the dose.the medication order is evaluated for.the dose.in agreement with the current clinical practice. Medical record review revealed Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of the 5-day Admission Minimum Data Set ((MDS) dated [DATE] revealed Resident #2 scored 12 on the Brief Interview for Mental Status (BI[CONDITION]) indicating no cognitive impairment. Continued review showed Antipsychotic medications were received the last 7 days with issues found during the review and contact made with medical services. Review of the internal facility investigation dated [DATE] showed Registered Nurse (RN) #1 reported on 2/21/2020 she received 2 medication lists from the family. On 1 list the times for administration of the [MEDICATION NAME] was for in the morning and in the evening. The information was entered into the computer. On 2/25/2020 the family for Resident #2 attending a baseline care plan meeting and reviewed the resident's medications. The family stated the [MEDICATION NAME] was only to be given in the evening; the changes were made. On [DATE] the family was returning Resident #2 to the facility from a Doctor's visit. The family stated the resident was receiving too much [MEDICATION NAME]. The list was reviewed with the family. RN #1 stated after reading the list with the family a discrepancy was observed for the dosage of [MEDICATION NAME]. The dosage 0.75 milligrams (mg) was entered into the computer and the list called for 0.375 mg. RN #1 stated she apologized to the family, made the change in the computer, called the Medical Director and DON. Interview with Registered Nurse (RN) #1 on 3/30/2020 at 11:00 AM in the conference room showed from 2/25/2020 to [DATE] the resident received the wrong dose of [MEDICATION NAME] (an Antipsychotic medication used to treat Behavioral Disturbance with Dementia). RN #1 confirmed the medication dosage was transcribed wrong on 2/25/2020 from a list the family brought from home. RN #1 also confirmed she transcribed the dosage as 0.75 milligrams (mg) instead of 0.375 mg. RN #1 further stated the discrepancy was found when she spoke with Family member #1 on [DATE]. Interview with the DON on 3/30/2020 at 2:00 PM in the conference room showed Resident #2 had been admitted to a behavioral health facility 1/2020 to monitor and control Behavioral Disturbances with Dementia. The [MEDICATION NAME] was prescribed to help control the Behavioral Disturbances. Family member #1 provided a list of the resident's medications. The DON confirmed on 2/25/2020 RN #1 transcribed the dosage of [MEDICATION NAME] as 0.75 mg instead of 0.375 mg.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.