F 000 INITIAL COMMENTS

Complaint investigation #31508, #31882, #31919, #31942, and #32148, were completed on September 9-10, 2013, at Kindred Nursing and Rehabilitation - Madison. No deficiencies were cited in complaint investigation #31882, #31919, #31942, and #32148. Deficiencies were cited related complaint investigation #31508 under 42 CFR Part 483, Requirements for Long Term Care Facilities.

F 425 483.60(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 ensure 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:

Based on medical record review and interview,

LABORATORY DIRECTOR OR PROVIDER/REPRESENTATIVE SIGNATURE

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 30 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.
<table>
<thead>
<tr>
<th>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>(X) PROVIDER/SUPPLIER IDENTIFICATION NUMBER</td>
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<td>444075</td>
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| NAME OF PROVIDER/SUPPLIER                     |
| MADISON HEALTHCARE AND REHABILITATION CENTER  |

**SUMMARY STATEMENT OF DEFICIENCIES**

- The facility failed to provide pharmacy services for three residents (#5, #6, #19) of twelve residents reviewed.

The findings included:

- Resident #5 was admitted to the facility on October 12, 2012, and readmitted August 8, 2013, with diagnoses including Dementia, Delirium, Chronic Pain Syndrome, Hypertension, Status Post Left Leg Amputation, and Osteoporosis.

- Medical record review of readmission Physician's Orders for August 8, 2013, revealed Exelon Patch (memory problems) 24 hour 4.6 mg/hr (milligram/hour) apply one patch transdermal (apply to skin) one time a day, Nazotrin Capsule (neuropathy pain) 100 mg give 2 caps by mouth one time a day, Serquel 50 (antipsychotic) mg by mouth at bedtime, and Norco Tablet (pain) 10-325 mg give one tablet by mouth three times a day.

- Medical record review of the Medication Administration Records (MARS) dated August 2013 revealed no medications were administered on August 9, 2013.

- Medical record review of a Physician's Telephone Order dated August 10, 2013, revealed "...Hold meds (medications) that are not available at this time - Resume meds when they arrive from pharmacy may (change) med times if necessary..."

- Medical record review of a Physician's Telephone order dated August 11, 2013, revealed "...All meds arrived along with box of Exelon Patches -

implemented timely with available medications. The Nurse Educator re-educated LPN #1 and LPN #2 and DON on not borrowing resident medication on 9/12/13.

4. The Director of Nursing/ Designee will audit/monitor the medication administration records three times a week for one month and then weekly for two months to ensure medication administration occurs per standard. The results of the audit/monitoring will be presented by the Director of Nursing to the Quality Assurance Performance Improvement team meeting for evaluation and revision to plan.

Date of compliance: October 31, 2013.
**F 425** Continued From page 2

Interview with the Director of Nursing (DON) on September 10, 2013, at 10:45 a.m., in the DON’s office revealed the facility had a change in pharmacy providers in August, and the resident's medication ordered on August 8, 2013, did not arrive until August 11, 2013. Continued interview revealed the resident missed two doses of Norco 10-325 mg, two doses of Seroquel 50 mg, and two Exelon Patches 4.6 mg/hr. Further interview confirmed the facility had failed to provide pharmacy services.

Resident #6 was admitted to the facility on August 21, 2013, with diagnoses including Renal Failure, Anemia, Hepatitis C, Chronic Obstructive Pulmonary Disease, and Cirrhosis.

Medical record review of an Interim Care Plan dated August 21, 2013, revealed "...Comfort Care...at risk for pain..."

Medical record review of a Physician’s Telephone Order dated August 22, 2013, at 7:00 p.m., revealed "...Roxanol (pain) 2.6 ml (milliliters) Q (every) 1 (hour) pm (as needed) Air Hunger, SOB (shortness of breath), pain..."

Medical record review of a Nurse’s Note dated August 22, 2013, at 7:45 p.m., revealed "...went into med select to obtain Roxanol. Med select stated insufficient quantity - call placed to back up pharmacy to (check) on situation awaiting return call..."

Medical record review of a Nurse’s Note written by Licensed Practical Nurse #1 (LPN #1) dated August 22, 2013, at 8:10 p.m., revealed "...Call

**F 514**

1. Resident #6 was assessed by the Director of Nursing on 9/16/13 for pain management and pain control. Resident expressed pain was controlled.

2. Resident receiving pain medication have the potential to be affected by the identified practice. The Director of Nursing conducted an audit on 9/16/13 of resident pain medication records to identify if any other omissions were found.
3. The Nurse Educator and Director of Nursing re-educated the licensed nursing staff and LPN #1 as to the medication ordering process to ensure medications (pain) were available for administration.

4. The Director of Nursing/designee will conduct medication administration record audits three times per week for one month and then weekly for two months in order to monitor compliance. The results of the audits will be presented to the Quality Assurance Performance Improvement Committee team to evaluate findings and revise plan as needed.

Date of compliance: October 31, 2013
### Statement of Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID PREFIX</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 425</td>
<td>Continued From page 4 revealed on documentation Heparin 5000 units SQ and the Metoprolol 25 mg had been given on August 28, 2013. Interview with LPN #2 on September 10, 2013, at 7:30 a.m., at the nurse's station revealed Metoprolol and Heparin had not been administered to the resident on the evening of August 28, 2013. Continued interview revealed LPN #2 had been waiting on approval and clarification of the orders and the medications had not arrived to the facility before the nurse's shift ended. Interview with the DON on September 10, 2013, at 9:05 a.m., in the DON's office confirmed the facility had failed to provide pharmacy services.</td>
<td>F 425</td>
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<td>F 514</td>
<td>C/O #61508 483.75(1)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</td>
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**MADISON HEALTHCARE AND REHABILITATION CENTER**

**Street Address, City, State, Zip Code**

423 LARKIN SPRING RD

MADISON, TN 37115

**ID**

**Prefix**

**Tag**

**Date Survey Completed**

09/16/2013
**F 514: Continued From page 5**

- Based on medical record review and interview, the facility failed to document administration of pain medication for one resident (#6) of twelve residents reviewed.

  **The findings included:**

  Resident #6 was admitted to the facility on August 21, 2013, with diagnoses including Renal Failure, Anemia, Hepatitis C, Chronic Obstructive Pulmonary Disease, and Cirrhosis.

  **Medical record review of an Interim Care Plan dated August 21, 2013, revealed “...Comfort Care...at risk for pain.”**

  **Medical record review of a Physician's Telephone Order dated August 22, 2013, at 7:00 p.m., revealed “...Roxicold (pain) 2.5 ml (mL) (every 1 hour) pm (as needed) Air Hunger, SOB (shortness of breath), pain...”**

  **Medical record review of a Nurse's Note dated August 22, 2013, at 7:45 p.m., revealed “...went into med select to obtain Roxicold, Med select stated insufficient quantity - call placed to back up pharmacy to (check) on situation awaiting return call...”**

  **Medical record review of a Nurse's Note dated August 22, 2013, at 8:10 p.m., revealed “...Call received from pharmacy re (regarding) meds (medication)...”**

  **Medical record review of the Medication Administration Records dated August 2013 revealed no documentation the Roxicold had been administered on August 22, 2013.**
**Statement of Deficiencies and Plan of Correction**

**[K1] Provider/Supplier Identification Number:**

445075

**C2 Multiple Construction**

A. Buildings

B. Wing

**Date Survey Completed:**

09/16/2013

**Name of Provider or Supplier:**

Madison Healthcare and Rehabilitation Center

**Address:**

431 Larkin Springs Rd

Madison, TN 37115

**Summary Statement of Deficiencies**

**Prefix Tag:** F 514

Continued From page 6

Interview with Licensed Practical Nurse #1 on September 10, 2013, at 10:08 a.m., in the Director of Nursing (DON) office, revealed the pharmacist informed the nurse the Roxarol would not be available for two hours. Continued interview revealed the DON had been notified and the Roxarol had been borrowed from another resident and administered to Resident #6. Further interview confirmed the Roxarol had not been documented as given in Resident #6’s medical record.

Interview with the DON on September 9, 2013, at 4:00 p.m., in the Conference Room revealed the pharmacy had informed the facility the Roxarol would not be delivered for two hours. Continued interview revealed the resident had been in pain and the DON instructed the nurse to borrow the pain medication from another resident. Further interview confirmed the facility failed to document the administration of the Roxarol to the resident.

C/O #31508