**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/ SUPPLIER/ CLA IDENTIFICATION NUMBER**

<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 172</td>
<td>SS=0</td>
<td>483.10(1)(1)(2) RIGHT TO/FACILITY PROVISION OF VISITOR ACCESS</td>
</tr>
</tbody>
</table>

The resident has the right and the facility must provide immediate access to any resident by the following:

- Any representative of the Secretary;
- Any representative of the State;
- The resident's individual physician;
- The State long term care ombudsman (established under section 307 (a)(12) of the Older Americans Act of 1965);
- The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act);
- The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act);

Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and

Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.

The facility must provide reasonable access to any resident by any entity or individual that

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**(X2) MULTIPLE CONSTRUCTION**

**A. BUILDING**

**B. WING**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1245 E COLLEGE ST
PULASKI, TN 38478

**06/21/2012**

**(X3) DATE SURVEY COMPLETED**

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**LABORATORY DIRECTORS OR PROVIDERS/ SUPPLIERS/ REPRESENTATIVES SIGNATURE**

**RECEIVED**

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correlling 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.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREMISE NUMBER</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 172</td>
<td>Continued From page 1</td>
<td>provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time. This REQUIREMENT is not met as evidenced by: Based on interview, it was determined the facility failed to ensure residents were provided with information related to the long term care ombudsman and how to contact the ombudsman. The findings included: During an interview in the conference room on 6/20/12 at 1:30 PM, the resident council president was asked if she knew who the ombudsman was. The resident council president stated, &quot;Don't know who the ombudsman is and don't remember ever being told.&quot;</td>
<td></td>
</tr>
<tr>
<td>F 279</td>
<td>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</td>
<td>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under 483.25; and any services that would otherwise</td>
<td>483.20(d), 483.20(k)(1) Develop Comprehensive Care Plans SS=B Requirement: A facility must use the results of the assessment to develop, review, and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under 483.25; and any services that would otherwise</td>
</tr>
</tbody>
</table>
F 279 Continued From page 2
§483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident’s exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

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 the care plan addressed dental, bruises and/or vision for 3 of 16 (Residents #75, 77 and 85) sampled residents of the 31 residents included in the Stage 2 review.

The findings included:

1. Review of the facility’s "Care Plans" policy documented, "The care plan process must begin upon admission into the facility and be fluid and changeable representing the patient's status until the patient is discharged from the facility or is deceased."

2. Medical record review for Resident #75 documented an admission date of 4/2/12 with diagnoses of Bilateral Lower Extremities Cellulitis with Chronic Venous Stasis Ulcers, Diabetes Mellitus, Neuropathy, Chronic Constipation, Hypertension, Chronic Obstructive Pulmonary Disease, Gastro Esophageal Reflux Disease, Schizophrenia, Anemia, Peripheral Vascular Disease, Hypothyroidism, Protein Calorie and Acid Peptic Disease.

Review of the Minimum Data Set (MDS) with an assessment reference date (ARD) of 4/7/12 had

F 279 be required under 483.25 but are not provided due to the resident’s exercise of rights under 483.10, including the right to refuse treatment under 483.10(b)(4).

Corrective Actions:
1. On 6/20/12, 6/21/12, and 6/29/12, the MDS Coordinator reviewed and revised resident’s #75, #77, and #85 care plan in regard to dental, bruises, and/or vision.
2. On 6/29/12, the MDS Coordinator reviewed and revised resident care plans for accuracy.
3. On 7/3/12, the Administrator and DON in-service the MDS Coordinator regarding the accuracy and revision of care plans.
4. The DON or designee will monitor for Compliance through random chart audits of care plans.

Completion Date: 7/3/12
<table>
<thead>
<tr>
<th>F 279</th>
<th>Continued From page 3</th>
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<tr>
<td>section B - vision was coded as 1 - indicating the resident had impaired vision and section B1200 corrective lenses was coded as 0 - indicating did not have corrective lenses. Review of the nurses' admission assessment dated 4/2/12 documented, Resident #75's vision was impaired and the resident wears glasses for reading. Review of the social service admission and history documented the resident's vision was impaired and used glasses for reading. The care plan dated 4/16/12 did not address the resident's impaired vision.</td>
<td></td>
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<tr>
<td>During an interview in the conference room on 6/20/12 at 3:05 PM, the MDS Coordinator verified the care plan did not address the resident's impaired vision.</td>
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<tr>
<td>Review of the MDS with an ARD of 4/7/12 for section L - for oral and dental status documented, &quot;...B - No natural teeth, K0100 - Swallowing- C- Coughing or choking during meals or when swallowing... K0510- Nutrition Approach - Mechanically altered diet...&quot;</td>
<td></td>
</tr>
<tr>
<td>Review of the &quot;Admission Nutrition Screen&quot; dated 4/2/12 documented, &quot;...ORAL STATUS... Edentulous&quot; was checked.</td>
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<tr>
<td>Review of the care plan dated 4/16/12 did not address the resident was edentulous or that the resident had swallowing/choking problems.</td>
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<tr>
<td>During an interview in the care plan coordinator's office on 6/21/12 at 7:45 AM, the MDS coordinator verified the care plan did not address the resident's swallowing and choking problems.</td>
<td></td>
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<tr>
<td>Review of the nurses' admission assessment</td>
<td></td>
</tr>
<tr>
<td>ID Prefix Tag</td>
<td>Summary Statement of Deficiencies</td>
</tr>
<tr>
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</tr>
<tr>
<td>F 279</td>
<td>Continued from page 4: &quot;...Multiple bruises and red areas on arms...&quot;</td>
</tr>
<tr>
<td></td>
<td>Observations in Resident #75's room on 6/19/12 at 3:00 PM, revealed Resident #75's seated in a wheelchair at the bedside with bruised, discolored red areas noted on his right lower wrist area.</td>
</tr>
<tr>
<td></td>
<td>Observations on the 200 hall on 6/20/12 at 11:00 AM and on 6/20/12 at 2:55 PM, revealed Resident #75 seated in a wheelchair, with red bruising noted on right and left lower arm.</td>
</tr>
<tr>
<td></td>
<td>During an interview at the 200 hall on 6/20/12 at 3:43 PM, Nurse #1 was asked about bruises on the resident's arm. Nurse #1 stated, &quot;I don't know what caused them [bruises].&quot;</td>
</tr>
<tr>
<td></td>
<td>Review of the care plan dated 4/16/12 did not address the bruises on Resident #75's arms.</td>
</tr>
<tr>
<td></td>
<td>During an interview in the care plan coordinator's office on 6/20/12 at 4:50 PM, the MDS coordinator verified there was not a care plan to address Resident #75's bruising.</td>
</tr>
<tr>
<td></td>
<td>3. Medical record review for Resident #77 documented an admission date of 12/12/11 with diagnoses of Stroke and Percutaneous Endoscopy Gastrostomy (PEG) tube. Review of the MDS with an ARD of 5/29/12 for section B1030 vision was coded as 2 - indicating the resident had impaired vision and section B1200 was coded as 0 indicating the resident did not have corrective lenses. The care plan dated 5/10/12 did not address Resident #77 required glasses.</td>
</tr>
</tbody>
</table>
F 279 Continued From page 5

Observations in Resident #77's room on 6/20/12 at 2:32 PM, revealed Resident #77 seated in a geri chair with glasses on reading a magazine.

Observations in Resident #77's room on 6/21/12 at 7:30 AM, revealed Resident #77 lying in bed with a book and magazine lying beside her. Resident #77 was alert with the television (TV) on.

During an interview at 200 hall nurses' station on 6/20/12 at 7:50 AM, Nurse #1 was asked about Resident #77's glasses. Nurse #1 stated, "I've been her since March of this year and I've never known her to wear glasses."

4. Medical record review for Resident #85 documented an admission date of 3/17/12 and a readmission date of 6/6/12 with diagnoses of Leukemia, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Atrial Fibrillation, Parkinson's Disease, Cerebrovascular Accident, Chronic Kidney Disease, Pulmonary Abscess, Hypertension, Gastro Esophageal Reflux Disease, Arthritis, Dementia with Behaviors and Urinary Tract Infection. Review of the admission MDS dated 3/24/12 documented, "...Section B1000. Vision Ability to see in adequate light (with glasses or other visual appliances) 1. Impaired - sees large print, but not regular print in newspapers / books... B1200. Corrective Lenses ... (contacts, glasses, or magnifying glass)... No..." Review of the admission care plan dated 6/6/12 documented, "...Vision Adequate... Wears glasses..."

Observations in Resident #85's room on 6/19/12 at 5:03 PM, revealed Resident #85 sitting up in
F 279 Continued From page 6

During an interview in Resident #85’s room on 6/20/12 at 8:50 AM, Resident #85 was asked if he wore glasses. Resident #85 stated, "No ma’am. I can see to read a little but the words run together. I couldn’t afford glasses. I need some, but I can’t afford it. I’ve never had a pair.”

During an interview in the conference room on 6/20/12 at 8:30 AM, the MDS Coordinator was asked if Resident #85 wears glasses. The MDS coordinator stated, "No, he hasn’t had any glasses that I am aware of. He didn’t at the time of his assessment.”

During an interview in the care plan room on 6/20/12 at 10:12 AM, the Social Worker (SW) was asked if she was aware of Resident #85’s vision needs. The SW stated, "No, I’m not aware of any needs for glasses." The SW was asked if she knew of any resources that assisted to provide glasses for residents if needed. The SW stated, "We used the Lions Club about two years ago... I don’t have a contact with them or any other group. I depend on the staff to relay any of the resident’s needs to me and then I would talk with the family. I didn’t know he had a need for glasses.”

F 260 483.20(g)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER
MEADOWBROOK NURSING CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1245 E COLLEGE ST
PULASKI, TN 38478

06/21/2012

DATE SURVEY COMPLETED

(033) 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)

(033) COMPLETION DATE

06/21/2012

F 280: Continued from page 7
A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident’s needs, and, to the extent practicable, the participation of the resident, the resident’s family or the resident’s legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not yet met as evidenced by:
Based on medical record review, observation and interview, it was determined the facility failed to provide services in accordance with the care plan for 1 of 3 (Resident #77) sampled residents reviewed of the 31 residents in the Stage 2 review.

The findings included:
Medical record review for Resident #77 documented an admission date of 12/12/11 with diagnoses of Stroke and Percutaneous Endoscopy Gastrostomy (PEG) tube. Review of the care plan dated 12/23/11 and updated 6/10/12 documented, “involve in activities not dependent on resident's ability to communicate: music, parties, movies... encourage activity attendance...”
Review of a hospital “History and Physical” dated

F 280

unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, the attending physician, registered nurse with responsibility for the resident and other appropriate staff in disciplines as determined by the resident’s needs and to extend practicable, the participation of the resident, the resident’s family or the resident’s legal representative and periodically reviewed and revised by a team of qualified persons after each assessment.

Corrective Action:
1. On 7/2/12 the Activity Director reassessed resident #77 activity preference and revised resident’s care plan,
2. On 7/2/12 the Activity Director reassessed the residents who stay in room for activity preferences and revised the residents care plan.
3. On 7/3/12 the Administrator and DON in-serviced the Activity Director regarding the importance of following the care plan for activities.
### F 280

Continued From page 8

12/12/11 documented, "At time of discharge, the patient is awake, alert, and follows commands with a dense right hemiparesis and accordingly she will be discharged to a skilled nursing facility."

Observations in Resident #77's room on 6/18/12 at 4:30 PM, on 6/19/12 at 8:15 AM and 11:15 AM and on 6/20/12 at 8:55 AM and 4:30 PM, revealed Resident #77 in her room.

During an interview at the 200 hall nurses station on 6/20/12 at 8:03 AM, the activity director stated, "...been bedfast ever since she [Resident #77] has been here..."

During an interview at the 200 hall nurses station on 6/20/12 at 8:15 AM, Certified Nursing Assistant (CNA) #2, was asked why Resident #77 was not taken to activities. CNA #2 stated, "...Get her up everyday... she stays in her room. Don't take her out because of the pump, its a dignity issue."

During an interview on the 200 hall nurses station on 6/20/12 at 9:40 AM, CNA #1 was asked if she takes Resident #77 out of the room to activities. CNA #1 stated, "Never take her to activities..."

CNA #1 was asked why Resident #77 was not taken to activities. CNA #1 stated, "...ask the activity director."

### F 282

483.20(l)(3)(i) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.
<table>
<thead>
<tr>
<th>F 282</th>
<th>Continued From page 9</th>
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<tbody>
<tr>
<td>This REQUIREMENT is not met as evidenced by:</td>
<td></td>
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<tr>
<td>Based on medical record review, observation and interview, it was determined the facility failed to follow the care plan interventions for activities for 1 of 3 (Resident #77) sampled residents reviewed of the 31 residents in the Stage 2 review.</td>
<td></td>
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<tr>
<td>The findings included:</td>
<td></td>
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<tr>
<td>Medical record review for Resident #77 documented an admission date of 12/12/11 with diagnoses of Stroke and Percutaneous Endoscopy Gastrostomy (PEG) tube. Review of the care plan dated 12/23/11 and updated 6/10/12 documented, &quot;Involving in activities not dependent on resident's ability to communicate: music, parties, movies... encourage activity attendance...&quot;</td>
<td></td>
</tr>
<tr>
<td>Review of a hospital &quot;History and Physical&quot; dated 12/12/11 documented, &quot;At time of discharge, the patient is awake, alert, and follows commands with a dense right hemiparesis and accordingly she will be discharged to a skilled nursing facility...&quot;</td>
<td></td>
</tr>
<tr>
<td>Observations in Resident #77's room on 6/18/12 at 4:55 PM, on 6/19/12 at 8:15 AM and 11:15 AM and on 6/20/12 at 8:55 AM and 4:30 PM, revealed Resident #77 in her room.</td>
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<tr>
<td>Random observations of Resident #77 through out all four days (6/18, 6/19, 6/20 and 6/21/12) of the survey revealed the resident was not taken</td>
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</table>
### Statement of Deficiencies and Plan of Correction

#### (X1) Provider/Supplier/Clinic Identification Number

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LSC identifying information)</th>
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<tbody>
<tr>
<td>F 282</td>
<td>Continued from page 10 out of her room to attend group activities.</td>
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<tr>
<td></td>
<td>During an interview at the 200 hall nurses' station on 6/20/12 at 8:03 AM, the activity director stated, &quot;...Been bedfast ever since she [Resident #77] has been here...&quot;</td>
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<td></td>
<td>During an interview at the 200 hall nurses' station on 6/20/12 at 8:15 AM, Certified Nursing Assistant (CNA) #2 was asked why Resident #77 was not taken to activities. CNA #2 stated, &quot;...Get her up everyday... she stays in her room. Don't take her out because of the pump, it's a dignity issue.&quot;</td>
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<td>During an interview on the 200 hall nurses' station on 6/20/12 at 9:40 AM, CNA #1 was asked if she takes Resident #77 out of the room to activities. CNA #1 stated, &quot;Never take her to activities...&quot; CNA #1 was asked why Resident #77 was not taken to activities. CNA #1 stated, &quot;...ask the activity director.&quot;</td>
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</table>

#### (X3) Date Survey Completed

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
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<tbody>
<tr>
<td>F 282</td>
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#### (X4) ID Prefix Tag

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<tr>
<th>SS=0</th>
<th>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</th>
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<tbody>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>This REQUIREMENT is not met as evidenced by:</td>
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<tr>
<td></td>
<td>Based on medical record review and interview, it was determined the facility failed to follow the</td>
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#### (X5) Completion Date

<table>
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<th>Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
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### Requirements

<table>
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<td>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.</td>
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</table>
F 309  Continued From page 11

physician's protocol for lack of a bowel movement (bm) for 1 of 15 (Resident #5) sampled residents reviewed of the 31 residents in the Stage 2 review.

The findings included:

Medical record review for Resident #5 documented an admission date of 2/13/07 with diagnoses of Irritable Bowel Syndrome, Chronic Renal Insufficiency Stage 3, Hypertension, Depression, Anxiety, Osteoarthritis, Chronic Urinary Tract Infection, Osteoporosis, Chronic Obstructive Pulmonary Disease, Hyperkalemia, Dementia, Paraanoia, Psychosis, Anemia, Reflux Esophagitis, Macular Degeneration and Degenerative Joint Disease.


Review of the bowel and bladder chart detail report had no documentation that Resident #5 had a bm from 5/6/12 through 5/11/12. There was no documentation an additional laxative had been given for lack of a bm from 5/6/12 through 5/11/12. There was no documentation Resident #5 had a bm from 5/13/12 through 5/17/12. There was no documentation that a pin laxative was given until 5/17/12.

During an interview at the 100 hall nurse's station on 6/20/12 at 1:50 PM, Nurse #3 was asked...
**MEADOWBROOK NURSING CENTER**

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<td>F 309</td>
<td>Continued From page 12 when should a resident be given a prn laxative for constipation. Nurse #3 stated, &quot;After 9 shifts or 3 days [with no bm]...&quot; Nurse #3 was asked if Resident #5 was given a prn laxative when she had no BM from 5/6/12 through 5/11/12. Nurse #3 reviewed the Medication Administration Record (MAR) and stated, &quot;I don't see that anything was given... She [Resident #5] should have been given something on the 3rd shift on the 8th.&quot; Nurse #3 was asked if Resident #5 received a laxative when she had no bowel movement from 5/13/12 through 5/17/12. Nurse #3 reviewed the MAR and stated, &quot;She should have gotten something [laxative] on first shift on the 16th. I don't see that she got anything until the 17th.&quot;</td>
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<tr>
<td>F 313</td>
<td>483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION</td>
</tr>
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</table>

- **SS=8D**: Develop Comprehensive Care Plans SS=8D

- **483.20(a), 483.20(a)(1), 483.20(b), 483.20(b)(1)**

**Requirement:**

A facility must use the results of the assessment to develop, review, and revise the resident’s comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being as required under 483.25; and any services that would otherwise be required under 483.25 but are not provided due to the resident's exercise of rights under 483.16, including the right to refuse treatment under 483.10(b)(4).
### Corrective Action:

1. On 6/20/12, 6/21/12, and 6/25/12, the MDS Coordinator reviewed and revised resident's #77, #77, and #85 care plans in regard to dental, bruises, and vision.

2. On 6/21/12, the MDS Coordinator reviewed and revised resident care plans for accuracy.

3. On 7/3/12, the Administrator and DON in reviewed the MDS Coordinator regarding the accuracy and revision of care plans.

4. The DON or designee will monitor for compliance through random chart audits of care plans.

### Completion Date: 7/3/12
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</thead>
</table>
| F 313         | Continued From page 14 appliances) 1. Impaired - sees large print, but not regular print in newspapers / books... B1200. Corrective Lenses... (contacts, glasses, or magnifying glass)... No..." Review of the admission care plan dated 6/8/12 documented, "...Vision Adequate... Wears glasses..." Observations in Resident #85's room on 6/19/12 at 5:03 PM, revealed Resident #85 sitting up in bed, watching a television program. During an interview in Resident #85's room on 6/20/12 at 8:50 AM, Resident #85 was asked if he wore glasses. Resident #85 stated, "No ma'am. I can see to read a little but the words run together. I couldn't afford glasses. I need some, but I can't afford it." During an interview in the conference room on 6/20/12 at 8:30 AM, the MDS coordinator was asked if Resident #85 wears glasses. The MDS coordinator stated, "No, he hasn't had any glasses that I am aware of. He didn't at the time of his assessment." During an interview in the care plan coordinators' room on 6/20/12 at 10:12 AM, the Social Worker (SW) was asked if she was aware of Resident #85's vision needs. The SW stated, "No, I'm not aware of any needs for glasses." The SW was asked if she knew of any resources that assisted to provide glasses for residents if needed. The SW stated, "We used the Lions Club about two years ago... I don't have a contact with them or any other group. I depend on the staff to relay any of the resident's needs to me and then I would talk with the family. I didn't know he had a need for glasses."
NAME OF PROVIDER OR SUPPLIER
MEADOWBROOK NURSING CENTER

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CJA IDENTIFICATION NUMBER:
445443

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
06/21/2012

STREET ADDRESS, CITY, STATE, ZIP CODE
1245 E COLLEGE ST
PULASKI, TN 38478

 SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECITED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

F 332 SS=0 483.25(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.

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 1 of 4 (Nurse #1) nurses administered medications with a medication error rate less than five percent (%). There were 6 medication errors out of 54 opportunities for error, which resulted in a medication error rate of 11.11%.

The findings included:

Review of the facility’s “Enteral Feeding” policy documented, “...Crush pill (if crushable), and mix with fluid to make a thin solution with small sediment...”

Medical record review for Resident #77 documented an admission date of 12/12/11 with diagnoses of Acute Left Middle Cerebral Artery Stroke, Atrial Fibrillation, Aphasira, Hypertension, Hyperlipidemia, and History of Urinary Tract Infection. Review of the physician’s orders dated 5/5/12 documented, “...ASPIRIN... 325MG [milligrams] ONE TAB [tablet] PER PEG [percutaneous endoscopy gastrostomy] EVERY DAY... CRESTOR... 5MG TAKE ONE TAB PER PEG TUBE EVERY DAY... DONEPEZIL 10MG... ONE TAB PER PEG TUBE EVERY DAY... FERROUS SULFATE... 220 [per] 5ML [milliliters]

ID PREFIX TAG

F 332
483.25 (m)(1)
Free of Medication Error Rates of 5% Or More
SS=-D

Requirement:
The facility must ensure that it is free of medication error.

Corrective Action:
1. On 6/19/12, the MD was notified that medications were not given as ordered. No new orders received.
2. Patient was monitored for adverse effects. On 6/19/12, nurse #1 was in-serviced on proper peg tube medication administration.
3. All resident with a peg tube has the potential to be affected by this practice.
4. On 7/3/12, the licensed nursing staff were in-serviced on proper procedure for medication administration per peg tube.

The DON or designee will conduct random peg tube medication administration audits for 1 nurse weekly on each shift for 2 weeks, then 2 nurses monthly for 3 months, then one nurse monthly on-going to ensure compliance with facility guidelines. Audit results will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.

Completion Date: 07/05/12

FORM CMS-2557(02-49) Previous Versions Obsolete
Event ID: 62CO11
Facility ID: TN2802
If continuation sheet Page 16 of 26
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 332</td>
<td>Continued From page 16</td>
<td>7 CC (cubic centimeters) PER PEG TUBE TWO TIMES DAILY... METOPROLOL... 25MG ONE HALF TAB PER PEG TUBE TWO TIMES DAILY... SERTALINE... 50MG ONE TAB PER PEG TUBE EVERY DAY...&quot; Review of a physician's telephone order dated 5/7/12 documented...&quot;Nexum 40mg... per PEG tube q [every] day...&quot;</td>
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<td>Observations on the 200 hall on 6/19/12 at 9:10 AM, Nurse #1 prepared the following medications (meds) for administration to Resident #77: Aspirin 325mg, Cretor 5mg, Donepezil 10mg, Ferrous Sulfate liquid 7ml, Metoprolol 25mg, Sertaline 50mg and Nexum granules 40mg. Nurse #1 poured the liquid Ferrous Sulfate into a medication cup, placed the Nexum granules in a med cup, and crushed the other medications and then placed in the cup with the Nexum granules. Nurse #1 entered Resident #77's room and placed the medications on the over bed table. Nurse #1 added approximately 30ml of water to the crushed medications and granules. Nurse #1 flushed the PEG tube with water, administered the Ferrous Sulfate liquid, and flushed again. Nurse #1 poured a partial amount of the medications/water mixture into the syringe connected to the tube. Nurse #1 poured approximately 30ml of water into the remaining crushed meds/granules and squeezed the sides of the medication cup in an attempt to dilute and thin. Nurse #1 then poured a partial amount of the medications into the tube. The medications obstructed the tube and would not flow through for administration. Nurse #1 poured the medications from the syringe into a cup of water and swirled the cup. The medications still did not dilute. Nurse #1 poured the medications into the</td>
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**F 332**
F 332 Continued From page 17
syringe to administer. The medications obstructed the tube again and would not flow. Nurse #1 poured the medications back into a cup, removed the syringe, and discarded the medications. The failure to administer all of the medications of Aspirin 325mg, Crestor 5mg, Donepezil 10mg, Metoprolol 25mg, Sertaline 50mg and Nexium granules 40mg resulted in 6 medication errors.

During an interview on the 200 hallway on 6/19/12 at 9:52 AM, Nurse #1 was asked why the medications would not flow through the PEG tube. Nurse #1 stated, "I don’t know. I think it’s those Nexium granules. I usually let them sit in water longer so they will dissolve and make a liquid."

F 371 483.35(i) FOOD PROCURe, SS=0
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 review of the facility’s "Dietary Services Training Manual", observation and interview, it was determined the facility failed to ensure food was protected from sources of contamination when a staff member failed to ensure her hair net

F 332

F 371

483.35 (i) FOOD PROCURe
STORE/prepare/serve
SANITARY

Requirement
The facility must -
(1) Procure food from sources considered satisfactory by Federal, State, or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary Conditions
F 371 Continued From page 18
covered her hair, a visitor did not enter the kitchen and if entering the kitchen wore a hair net, and dishes were not stored wet nesting on 3 of 4 (6/18/12, 6/20/12 and 6/21/12) days of the survey.

The findings included:

1. Review of the facility's "Dietary Services Training Manual" Chapter 4, Page 2 documented, "...Hair covering must be worn at all times with all hair under covering..."

Observations in the dining room on 6/18/12 at 11:30 AM, revealed the Dietary Manager (DM) serving food from the steam table with the right side and right back of her hair uncovered by a hair net.

Observations in the dining room on 6/18/12 at 11:40 AM, revealed Visitor #1 entered the food preparation area of the kitchen without a hairnet.

Observations in the dining room on 6/20/12 at 11:00 AM, revealed Dietary Worker #1 entered the food preparation area of the kitchen without a hairnet.

During an interview in the conference room on 6/20/12 at 2:25 PM, the DM was asked where a hair net was to be worn. The DM stated, "...in the food preparation area..." The DM was asked who the use of a hair net referred to. The DM stated, "Everyone."

During an interview in the kitchen on 6/21/12 at 8:10 AM, the DM was asked about how hair nets should be worn. The DM stated, "...it [hair net] should cover all the hair..."
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDERS PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>F 371</td>
<td></td>
<td>Continued From page 19</td>
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</table>

2. Review of the facility's "Dietary Services Training Manual" Chapter 8 Page 6 documented, "...Allow clean dishes to air dry completely before storing..."

Observations in the kitchen on 6/21/12 at 8:05 AM, revealed eight clear plastic bowls stacked wet nesting and five clear plastic bowls stacked wet nesting.

During an interview in the kitchen on 6/21/12 at 8:10 AM, the DM confirmed the clear plastic bowls were stacked wet nesting.

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation, and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.
<table>
<thead>
<tr>
<th>F 431 Continued From page 20</th>
<th>F 431</th>
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<tbody>
<tr>
<td>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</td>
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**Corrective Action:**

1. On 6/20/12, nurse #2 was immediately in-serviced on medication storage and expiration/open date guidelines. The expired glucose solution was discarded. A quality control test was performed with the new glucose solution. All med carts were audited for expired medications with none found.
2. All residents who require a fingernail glaucoma have their potential to be affected by this practice.
3. On 7/15/12, all licensed nursing staff were in-serviced on the proper medication storage and expiration/open date guidelines.
4. Medication expiration dates will be audited by the pharmacist consultant monthly and the DON or designee will conduct on-going random audits to ensure compliance with facility guidelines. Audit results will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.

**Completion Date:** 7/26/12
<table>
<thead>
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<th>CERTIFICATION DATE</th>
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</thead>
<tbody>
<tr>
<td>F 431</td>
<td>Continued From page 21 how long the glucose control solution can be used after it was opened on 2/3/12. Nurse #3 stated, &quot;It's only good for 90 days.&quot;</td>
<td>F 431</td>
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<tr>
<td>F 441</td>
<td>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</td>
<td>F 441</td>
<td>483.65 Infection Control, Prevent Spread, Linens</td>
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<td>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.</td>
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<td>(a) Infection Control Program</td>
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<td>(1) Investigates, controls, and prevents infections in the facility;</td>
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<td>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</td>
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<td>(b) Preventing Spread of Infection</td>
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<td>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</td>
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<td>(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.</td>
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<td>(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.</td>
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<td></td>
<td>(c) Linens</td>
<td></td>
<td>(1) Linens</td>
<td>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</td>
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<td></td>
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<td>(2) Linens</td>
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### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
<thead>
<tr>
<th>(x1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:</th>
<th>(x2) MULTIPLE CONSTRUCTION</th>
<th>(x3) DATE SURVEY COMPLETED</th>
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<tr>
<td>445443</td>
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<td>06/21/2012</td>
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</table>

**NAME OF PROVIDER OR SUPPLIER:**

**MEADOWBROOK NURSING CENTER**

**F 441 Continued From page 22**

Transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

Based on review of a manufacturer's instructions, policy review, observation and interview, it was determined the facility failed to ensure infection control practices were followed when 2 of 2 (100 hall and 200 hall medication carts) medication carts had a dirty pill splitter, 1 of 1 nurse (Nurse #1) disposed of a used lancet in a trash can; 1 of 4 nurses(Nurse #1) failed to wash her hands after removing gloves and 1 of 3 certified nursing assistants (CNA #3) turned the water off with her bare hand.

The findings included:

1. Observations at the 100 hall nurses' station on 6/20/12 at 3:21 PM, revealed a pill splitter stored inside the medication cart. The pill splitter had a white residue on the inside.

During an interview at the 100 hall nurse's station on 6/20/12 at 3:21 PM, Nurse #2 was asked if the pill splitter (in the 100 hall medication cart) was clean. Nurse #2 stated, "No. That's Mobic [white residue]. It's the last pill I split." Nurse #2 was asked how often should the pill splitter be cleaned. Nurse #2 stated, "Usually clean after every time I use it. I should have cleaned it."

Observations on the 100 hall on 6/21/12 at 8:25 AM, revealed an unclean pill splitter stored in the 100 hall medication cart. Nurse #5 was asked if...
F 441 Continued From page 23

the pill splitter was clean. Nurse #5 stated, "No, I will clean it now."

Observations at the 200 hall nurses' station on 6/19/12 at 9:05 AM, revealed Nurse #1 removed the pill splitter from the 200 hall medication cart. When Nurse #1 opened the pill splitter to half a tablet, there was a white residue on the inside of the splitter. Nurse #1 looked at the splitter and stated, "He [referring to another nurse] was just nice enough last night to not clean it."

During an interview at the 200 hall nurse's station on 6/19/12 at 9:10 AM, Nurse #1 was asked how often should the pill splitter be cleaned. Nurse #1 stated, "Supposed to clean it after every use."

Observations on the 200 hall on 6/21/12 at 8:20 AM, revealed an unclean pill splitter stored in the 200 hall medication cart.

During an interview on the 200 hall, beside the 200 hall medication cart, on 6/21/12 at 8:20 AM, Nurse #4 was asked if the pill splitter was clean. Nurse #4 stated, "No, it has something white in it."

2. Review of the "[Brand name] Pressure-Activated Safety Lancets" manufacturer's instructions documented, "...Dispose of safety lancet in Sharps container."

Review of the facility's "Infectious and Hazardous Waste" policy documented, "...Sharps are discarded in appropriately marked containers and placed in biohazard area..."

Observation on the 200 hall on 6/18/12 at 4:46
### F 441

Continued From page 24

PM, Nurse #1 entered room #210 B, donned a pair of gloves and obtained a blood sample by performing a fingerstick using a lancet. Nurse #1 removed the gloves, wrapped the lancet in the gloves with a paper towel, and placed the lancet in the trash can in the resident's bathroom.

During an interview at the 200 hall nurses' station on 6/18/12 at 4:49 PM, Nurse #1 was asked how did she dispose the lancet sharp. Nurse #1 stated, "I should have put it [lancet] in the sharps box. I usually just wrap it up in my glove and put it in the trash can. I should put it in the sharps box."

During an interview in the conference room on 6/21/12 at 7:45 AM, the Director of Nursing (DON) was asked what was the proper disposal of a sharp instrument such as a lancet. The DON stated, "We follow the manufacturer's instructions... place in a sharps box."

3. Review of the facility's "Hand Hygiene" policy documented, "...Hand hygiene must be accomplished... After removing gloves..."

Observations on the 200 hall on 6/18/12 at 4:46 PM, Nurse #1 removed a glucometer from the medication cart, donned gloves, cleaned the glucometer, pulled up medications from the cart and removed the gloves from her hands. Nurse #1 did not wash her hands after removing the gloves. Nurse #1 donned gloves, placed medications into a cup and removed the gloves. Nurse #1 did not wash her hands, after removing the gloves from her hands.

4. Review of the facility's "HANDWASHING" policy documented, "...9. Turn off faucet with a
SECOND clean dry paper towel or a DRY section of a previously used paper towel...

Observations in room 107 on 6/18/12 at 11:43 AM, CNA #3 set the meal tray on the overbed table, washed her hands and turned the water off with her bare hand. CNA #3 then returned to the bedside and set up the tray. CNA #3 went into the bathroom, washed her hands and turned the water off with her bare hand.