A Comprehensive Federal monitoring Survey was conducted on 3/26-29/12. The facility was found not in compliance with Medicare regulations at 42 CFR 483.6-Breath R-Requirements for Long Term Care facilities. The facility's census was 88.

F 309 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.

This REQUIREMENT is not met as evidenced by:

Based on record review, resident interview, staff interview and "Pain Assessment and Management" policy review, the facility failed to ensure the parameters for the administration of as needed (PRN) pain medications was defined and failed to monitor the effectiveness of pain medication administered for one (1) of all non-cognitive residents (Resident #1).

The findings include:

Resident #1 was admitted on 8/2/10 with diagnoses which included Chronic Back Pain, Arthritis, Hemorrhoids, and Shingles.

Review of Resident #1's Physician's Orders revealed an order, dated 3/3/11, for Lortab

7/17/12

F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each Resident will receive and the facility must provide the necessary care and the services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

1) On 6/29/12 Resident #1 orders for Tylenol and Lortab were clarified with the attending physician to define parameters as follows: May give Tylenol 650mg every four hours as needed for pain, may give Lortab 7.5/500mg every four hours for pain not controlled with Tylenol. The Pain Assessment Flow sheet will be used to record pain assessment ratings and follow-up of effectiveness of pain medication. The FLACC pain scale will be used for rating non-cognitive residents' pain. This was implemented 7/17/12 after all licensed staff were in-serviced.

2) On 07/11/2012 the DON, ADON, Risk Manager and Consultant
Pharmacist began checking all other residents’ charts for pain medication orders noting parameter clarification, reviewed MARs for correct rating of pain medication using 0 – 10 rating scale, and recording follow-up for medication effectiveness. This was completed on 7/17/12.

3) On July 17th 2012 an in-service was conducted with all licensed nursing staff concerning the requirements of facility policy on recording the rating of pain prior to giving pain medication; parameters for more than one pain medication ordered; using the Pain Assessment Flow Sheet; follow-up on the effectiveness of the pain medication; and using the FLACC Rating Scale for non-cognitive residents. (See Attachment) DON will monitor for nurses not following pain assessment policy and implement disciplinary action to address non-compliance. The DON will conduct quarterly in-services with all licensed nursing staff on the above topics to ensure compliance with policy on pain Assessment and Management beginning July 17, 2012 and continue for 1 year or until substantial compliance has been obtained.
Continued From page 2

palliative care.

F 309 The DON, ADON, Risk Manager, MDS Coordinator will review the MARs weekly for 6 weeks and monthly x 3 months or until goal is met for documentation compliance of palliative care.

F 309

4) The DON will report the outcomes of monitoring quarterly pain assessment and documentation to the Quality Improvement Committee on July 19, 2012 and then at each quarterly QI Committee meeting until compliance is achieved. The Administrator will report outcomes of the QI committee meetings to the monthly Board of Directors meetings.

7/17/12

The next meeting is scheduled for July 24, 2012.

The facility will procure food from sources approved or considered satisfactory by Federal, State, or local authorities, and store, prepare,
**F 371 Continued from page 3**

This REQUIREMENT is not met as evidenced by:

Based on observation and staff interview, the facility failed to ensure all food items were labeled and dated, expired foods were discarded and not available for use and packages of raw meat were not stored next to and below ready to eat foods for fifty nine (59) residents consuming food.

The findings include:

An initial tour of the facility was conducted on 8/25/12 at 3:30 p.m., along with the Dietary Manager (DM). The following areas of concern were identified in the reach in cooler:

1. Two boxes of raw bacon stored above a box of individual cartons of milk.
2. Two boxes of raw sausage stored next to four trays of individual plastic bowls of peaches covered with plastic wrap and above a box of individual cartons of milk.
3. Two bottles of soda that according to the DM, belonged to staff.
4. One package of sliced deli ham without a date opened.
5. One plastic bag of raw beef patties on top of two trays of individual health shakes.
6. One five pound container of cottage cheese without a date opened.
7. One two pound container of goat cheese without a date opened.

The Dietary Manager stated all items should be dated when opened when they are refrigerated and she was not aware the raw bacon, sausage

### F 371

Distribute and serve food under sanitary conditions.

1) On 6/30/12 the Dietary Manager discarded all opened foods that did not have a date, expired foods, and moved any raw meats stored next to or below ready to eat foods.

On 7/1/2012 the dietary Manager implemented a new checklist system for the kitchen staff to use for labeling refrigerated food products properly (especially putting an "opened date on opened products in the refrigerator), and to include making sure expired food products are thrown out and not available for use, and that raw meats are stored below and not beside ready to eat foods (see attached checklist system)

2) On 7/3/2012 the Dietary Manager conducted a mandatory in-service for all dietary employees on the new checklist system for proper labeling of refrigerated food items to include the "opened date on opened refrigerated products, throwing out of expired products so they are not available for use, and storing raw meats below and beside ready to eat products.
F 371 Continued from page 4
and beef were not served below ready to eat
foods.

F 428 483.60(c) DRUG REGIMEN REVIEW, REPORT
IRREGULAR, ACT ON

The drug regimen of each resident must be
reviewed at least once a month by a licensed
pharmacist.

The pharmacist must report any irregularities in
the attending physician, and the director of
nursing, and these reports must be acted upon.

This REQUIREMENT is not met as evidenced by:
Based on record review, "Medication Regimen
Review" policy review and staff interview, the
facility failed to ensure the Medication Regimen
Review identified potential problems to the
Attending Physician and the Director of Nursing
(DoN) in regards to: (1) parameters defined for
the administration of pain medications for one (1)
of 15 sampled residents (Resident #1), (2)
monitoring of the effectiveness of pain
medications administered to two (2) of 16
sampled residents (Residents #1 and 6), and (3)
monitor the use of a psychotropic medication and
provide documentation to the physician for one
(1) sampled resident (Resident #4).

The findings include:
1. Resident #1 was admitted on 6/2/10 with
diagnosis which included Chronic Back Pain.

3) To ensure the deficient practice
does not recur, beginning 07/17/2012,
the Dietary Manager or designee will
use the new checklist system daily for
60 days and then weekly thereafter.

4) The Dietary Manager will survey the
refrigerator daily to see that the new
checklist system is in compliance. In
addition, the Dietary Manager will
review the staff's Checklists to see that
they are being completed correctly and
in a timely manner. The Dietary
Manager will report outcomes of the
new checklist system to the CQ
Committee beginning on 7/19/2012
and then at each quarterly CQ meeting
until compliance is achieved. The
Administrator will report outcomes to
the monthly Board of Directors
meetings beginning 07/24/2012.

F 428 483.60 DRUG REGIMEN
REVIEW, REPORT IRREGULAR, ACT ON

The drug regimen of each resident will be
reviewed at least once a month by a
licensed pharmacist. The pharmacist
will report any irregularities to the
attending physician, and the director of
nursing, and these reports must be
acted on.
**Statement of Deficiencies**

**Humphrey's CO Nursing Home**

<table>
<thead>
<tr>
<th>Summary Statement of Deficiencies</th>
<th></th>
<th>Provider's Plan of Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Each deficiency must be preceded by full Regulatory or LSC identifying Information)</td>
<td></td>
<td>(Each corrective action should be cross-referenced to the appropriate deficiency)</td>
</tr>
</tbody>
</table>

**F 428 Continued from page 5**

Arthritis, Hemorrhoids, and Shingles.

Review of the resident's Physician Orders revealed orders for Lortab 7.5-600 milligrams (mg) by mouth three (3) times daily for Arthritis Pain (effective 8/21/12), Lorazepam 0.5 mg by mouth (1 tablet every four (4) hours) and Acetaminophen 325 mg (give 2 tablets) by mouth every four (4) hours PRN for pain or increased temperature (effective 8/29/11). The Directing Nursing (DON) confirmed that no parameters were defined within Resident #1's medical record instructing the Nurse on how and when Lortab and Acetaminophen should be administered for pain.


Review of the "Medication Regimen Review" policy, dated October 15, 2005, revealed "The Consultant Pharmacist will review the medication regimen of each resident at least monthly and report any irregularities to the Director of Nursing Services, the Attending Physician, and when appropriate, the Administrator and Medical Director. Notation of irregularities and/or potential problems shall be submitted to the Attending Physician and Director of Nursing Services. The Nurse and/or Physician must read the findings of the Consultant Pharmacist and they must act upon the findings of the Consultant Pharmacist. A medication regimen review comment not requiring a Physician Order (such as a request for blood pressure monitoring)."

1) On 6/29/12 the DON reported to Consultant Pharmacist the deficient practice of past Medication Regimen Review conducted by the Pharmacist. The DON obtained a clarification order for resident #1 on 6/29/12 for the Tylenol and Loratone.

Resident #6

The DON implemented the FLACC Pain Assessment in addition to the PRN Pain Flow Sheet on 7/17/12 for use by the licensed nursing staff to improve in capturing the rating of pain and follow-up effectiveness. The FLACC Pain Scale will be used for rating non-cognitive residents' pain.

Resident #4

On 7/11/12 the Consultant Pharmacist reviewed Resident #4 medications for any needed changes especially her Haldol medication. This was communicated to the Attending Physician on 7/11/12 by the Consultant Pharmacist.

2) On 7/11/12 the DON, ADON, Risk Manager and the Consultant Pharmacist began checking all other residents' charts with more than one pain medication to identify any needed
F 428 Continued From page 5

etc.) may be directed to the Nursing Staff. As such, Nursing may document their responses directly on the medication regimen review form."

During interview with the Pharmacy Consultant on 8/28/12 at 4:45 p.m., he stated parameters should be stated by the Ordering Physician for how and when PRN pain medications should be administered and Nurses should not make that judgment. He also stated, to monitor the effectiveness of PRN pain medications as well as the need for an adjustment in the pain medication, the Pharmacy Consultant would review the pain values documented on the PRN Pain Management Sheets.

The Medication Regimen Review forms for Resident #1, dated monthly from 6/26/11 to 6/26/12, did not address the lack of parameters for the PRN pain medications nor did it address the lack of monitoring for the effectiveness of the PRN pain medications.

2. Resident #3 was admitted on 10/6/11 with diagnoses which included Dementia, Polymyalgia Rheumatica, Osteoarthritis, Alzheimer's and Depression. Review of the resident's medical record revealed a Physician's Order, dated 11/28/11, for the resident to receive one Hydrocodone 5/100 mg tablet (used for moderate to severe pain) at 8:00 a.m. and 8:00 p.m., one 500 mg tablet of Acetaminophen (used for mild to moderate pain) at noon and 4:00 p.m. and one Hydrocodone 5/100 mg tablet every four hours as needed for pain.

Review of the facility's "Pain Assessment and clarification of parameters and monitoring charts to note the number of records with pain medication given, but pain not rated prior to giving pain medication and follow-up on pain effectiveness. This was completed on 7/17/12.

On July 12, 2012, the DON & Pharmacy Consultant began working on a communication process to ensure that the Pharmacy Consultant would have the information necessary to conduct an appropriate Medication Regimen Review. The communication process includes reviewing each area needing improvement and will involve a 15 - 30 minute review to discuss detailed findings and any needed changes. The DON & Pharmacy Consultant will meet 7/17/12 to review the Medication Regimen Review report and continue on a monthly basis until assurance of an adequate review has been achieved.

3) On July 17, 2012 an in-service was conducted for all licensed nursing staff by the DON concerning the requirements of facility policy on recording the rating of pain prior to giving pain medication and follow-up on the effectiveness of the pain
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENRS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

[41] PROVIDER IDENTIFICATION NUMBER
445469

[42] MULTIPLE CONSTRUCTION
& BUILDING
R. WING

[43] DATA SURVEY COMPLETED
08/29/2012

NAME OF PROVIDER OR SUPPLIER
HUMPHREY'S CO. NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
676 HIGHWAY 13 SOUTH
WAVERLY, TN 37185

[44] ID
PERSON
TAG
SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LEG IDENTIFYING INFORMATION)

ID
PERSON
TAG
PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

[45] COMPLETION DATE

F 428 Continued From page 7
Management policy stated the following: "Review the medication administration record to determine how often the individual requests and receives pain medication, and to what extent the administered medications relieve the resident's pain. Utilize pain scale from 1-10 to assess pain: 0-no pain, 1-2 Discomfort, 3-5-69, 10-worse pain. Document the resident's level of pain with adequate detail (i.e., enough information to gauge the status of pain and the effectiveness of interventions for pain) as necessary. Monitor the resident's response to interventions and level of comfort over time."

Review of the MAR and Pain Flowsheet for February 2012, revealed a pain scale of 1-3 had been used to assess the resident's level of pain. The resident's pain level had been assessed as a 2 on seven occasions indicating moderate pain. According to the facility's policy a level two was discomfort only.

Review of the facility's policy for Medication Regimen Review revealed, "...in performing the review [medication regimen], it is necessary that the pharmacist has access to the other pertinent documentation that would assist the pharmacist in making a professional judgment as to whether or not irregularities exist in the medication regimen."

Review of the MAR for March, May and June 2012, revealed the Pain Flowsheets utilizes a scale of 1-10 for pain but were not used consistently to monitor the resident's level of pain after the administration of pain medication or date and time the resident had requested additional medication.

F 428 medication. On 7/12/12 the Pharmacy Consultant re-reviewed the regulations on Medication Regimen Review to ensure she understands all requirements expected in the reviews.

4) The DON will report the outcomes of monitoring pain assessments, documentation of pain follow-up and Pharmacy Medication Regimen Review to the Quality Improvement Committee on July 19, 2012 and then at each quarterly QI meeting until compliance is achieved. The Administrator will report outcomes of the QI committee meetings to the monthly Board of Directors meetings. The next meeting is scheduled for July 24, 2012.
F 428 Continued from page 5

3. Resident #4 was admitted to the facility on 12/04/04 with diagnoses of Huntington’s Disease, Seizures, Psychosis, Depression, Scoliosis, and Hemiplegia. Review of the current Physician’s Orders revealed the resident received 10 mg of Haldol (an anti-psychotic) by mouth (PO) twice a day, 15 mg of Haldol PO every evening, and 135 mg of Haldol Intramuscular (IM) every four weeks. Review of the resident’s care plan, dated 8/1/11, identified the resident as having the potential for side effects related to the use of anti-psychotic medication for Huntington’s Disease.

Review of Psych-Services Medication Evaluation for 3/1/12 and 6/1/12, revealed the resident was identified as receiving Haldol as a psychotropic medication for the diagnosis of Huntington’s Disease. Review of the Pharmacy Consultant Reports revealed no evidence the pharmacist had made note to the resident’s physician regarding the use of Haldol.

In an interview with the Consultant Pharmacist Supervisor on 6/28/12 at 4:50 p.m., she stated the use of Haldol should be monitored by the pharmacist monthly and communicated to the physician regarding the long-term use of the drug.

F 460 483.70(d)(1)(iv)(w) BEDROOMS ASSURE FULL VISUAL PRIVACY

Bedrooms must be designed or equipped to assure full visual privacy for each resident. Except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.

F 460 483.7 BEDROOMS ASSURE FULL VISUAL PRIVACY

Bedrooms must be designed or equipped to assure full visual privacy for each resident. Except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.
F 480  Continued From page 9

uncepti in private rooms, each bed must have
calling suspended curtains, which extend around
the bed to provide total visual privacy in
combination with adjacent walls and curtains.

The REQUIREMENT is not met as evidenced by:

Based on observation and staff interview, the
facility failed to ensure that each bed was
equipped with a privacy curtain that provided full
visual privacy for at least 32 of 34 resident rooms and two
(2) of ten (2) common baths.

The findings include:

During the environmental tour of the facility on
6/28/12 at 6:30 p.m. along with the Maintenance
Supervisor, the following concerns regarding
privacy curtains were noted:

The privacy curtains between the beds in the 32
and private rooms were not configured to extend
around the bed closest to the window in order to
provide total visual privacy. The track for the
curtain between the two beds was designed to
allow the curtain to either go straight across the
room or around the bed closest to the door.
When the curtain is fully extended from one wall
to the other, access to window and closet is
blocked for the resident that resides in the area
located near the door.

The Common Bath on the West and East
Hallways did not have a shower curtain in front of
one of the two shower stalls used for resident
baths.

1) New privacy curtains and tracks were ordered 6/29/12 to replace old
curtains tracks throughout facility.
The Maintenance Supervisor installed a
new shower curtain for each of the
resident shower rooms on East and
West Halls on 6/28/12.
2) On 6/29/12 the DON surveyed all
resident rooms and found that all
rooms needed new curtains and tracks
to ensure full resident privacy is
provided, and to make certain that the
residents on the A side aren't blocked
from getting to their closet or seeing
out the window. The new system will
include two tracks and curtains for
each room, providing full privacy for
both the A and B bed, and providing
the A bed resident space to get to their
closet and to see out the window. The
approximate delivery date is four
weeks or 7/29/2012. The maintenance
staff will install the new equipment
within two weeks of the delivery date,
or approximately 08/15/2012. (See
attached purchase order)

On 7/17/2012 the DON conducted a
facility wide in-service for RNs, LPNs,
and CNAs on use of shower curtains
for privacy for the residents in the East
F 450 Continued From page 10
In an interview with the Maintenance Supervisor at the time of the observation, he stated the rooms were not configured to provide the bed next to the window with full privacy. He also confirmed the absence of a shower curtain in the two Common Bathrooms.

F 460 and West Shower Rooms. The staff was instructed to maintain resident privacy by using the shower curtains when bathing residents.

3) The Maintenance Supervisor will promptly install curtain tracks and curtains upon delivery. To prevent recurrence, the Maintenance supervisor will respond promptly to any work orders reported by the nursing staff when any trouble is noted with the privacy curtains or tracks in the resident rooms and the East and West Hall Shower rooms.

4) The next QI Committee meeting is scheduled for 07/19/2012 and the DON will provide a report on the projected arrival of the new privacy curtains and tracks and follow up at next scheduled QI meeting. The Administrator will report outcomes at the monthly Board of Directors meeting on 07/24/2012 and monthly until compliance is achieved.