LAURELWOOD HEALTHCARE CENTER

F 159 SS-5
483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS

Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.

The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the checking account falls below $200.00.

This plan of correction is submitted as required under state and federal law. The submission of this plan of correction does not constitute an admission on the part of Laurelwood Healthcare Center to the accuracy of the surveyor's findings nor the conclusions drawn therefrom. The facility's submission of this plan of correction does not constitute an admission on the part of the facility that the findings cited are accurate, but that the findings constitute a deficiency, or that the scope and severity regarding any deficiencies cited are correctly applied.

All account balances including Resident #s 15, 16, 29, 38, 47, and 62 were less than $200.00 of the resource allowance as of 03/20/13.

Each resident and/or representative was notified of their account balance on 03/08/13 by the Administrator and Business Office Manager.

The Business Office Manager will review all accounts weekly and with the Social Services Director monthly. Social Services will notify the patient and/or representative at any time that the account balance is within $200.00 of the resource limit.
Continued From page 1

The Social Service Director will notify each resident 03/20/13 that receives Medicaid benefits when the amount in the resident's account reaches $220.00 less than the SSI resource limit for one person.

The Social Worker and Business office Manager were in service by the Administrator on 03/09/13 regarding monthly review of account balances and notifications to the family.

The Administrator will monitor weekly times 8 weeks or until 100% compliance. The Business Office Manager will present the result of the weekly audit to the Quality Assurance/Performance Improvement Committee monthly for three months and/or substantial compliance is achieved. The Quality Assurance/Performance Improvement Committee include the Administrator, Director of Nursing, Admissions/ Social Services Director, Activities, Rehabilitation Director, Maintenance, Dietary Manager, and Medical Director.

During an interview in the conference room on
F 159 Continued From page 2
3/6/13 at 8:50 AM, the Administrator stated, "This company does not take cut their portion when a resident goes to the hospital and returns getting skilled services. I have talked with them about this but they have explained that they do not do this. When I got here there were several residents with high account balances. The staff was spending them down by buying recliners and clothes. I stopped that because I felt there were other things they needed. We now try to talk with family members and find out about burial insurance and tombstones. We have been spending down now by buying burial insurance, have bought some rocks, have also bought the resident a lift, have bought televisions. We knew we were not where we should be..."

F 176 F 159
483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE

An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.

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 have an assessment for self administration of medications for 1 of 32 (Resident #29) sampled residents included in the stage 2 review.

The findings included:
Review of the facility's "SELF-ADMINISTRATION OF MEDICATIONS BY RESIDENTS" policy
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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**NAME OF PROVIDER OR SUPPLIER**

LAURELWOOD HEALTHCARE CENTER

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

200 BIRCH ST

JACKSON, TN 38301

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<th>ID PREFIX TAG</th>
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| F 176 | Continued From page 3 documented, 
"...Residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility..."|

Review of the facility's "RESIDENT RIGHTS" booklet documented, 
"...(n) Self-administration of drugs. An individual resident may self-administer drugs if the interdisciplinary team, has determined that this practice is safe..."

Medical record review for Resident #29 documented an admission date of 11/27/06 and a readmission date of 6/27/11 with diagnoses of Aphasia, Hypertension, Chronic Airway Obstruction, Late Effects of Cerebrovascular Accident, Schizophrenia, Generalized Anxiety, Epilepsy and Insomnia. Review of a physician's order dated 1/5/13 documented, 
"...ALBUTEROL 0.083% [ percent] SOLN [solution] NEBULIZER TREATMENT EVERY 6 HOURS..." Review of the care plan update documented, 
"...pt [patient] wanting to administer own breathing tx [treatment]....make sure pt is able to give own breathing tx..."

Observations in Resident #29's room on 3/5/13 at 2:35 PM, revealed Resident #29 sitting in his wheelchair at the bedside self-administering a nebulizer treatment with no nurse in the room with Resident #29.

During an interview on the 200 hall on 3/5/13 at 2:35 PM, the Assistant Director of Nursing (ADON) was asked if Resident #29 usually administered his own nebulizer treatment. The ADON stated, "Oh, yes ma'am, he is pretty..."
**NAME OF PROVIDER OR SUPPLIER**
LAURELWOOD HEALTHCARE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**
230 BIRCH ST
JACKSON, TN 38301

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

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**PROVIDER'S PLAN OF CORRECTION**
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)

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**Continued From page 4 alert...**

During an interview at the nurses' station on 3/7/13 at 11:35 AM, Nurse #1 and Nurse #2 were asked what is required for a resident to self administer medications. Nurse #1 and Nurse #2 both stated, "Have to have a Doctor order and we don't fill a form, I forgot the name of the form..." Nurse #1 and Nurse #2 both stated, "There is no resident here currently self administering [medications]."

During an interview at the nurses' station on 3/7/13 at 11:35 AM, Nurse #1 stated, "We use to have one resident [referring to Resident #29] that self administered but after the doctor had written the order he decided the resident was safe to self administer his own nebulizer because he would try to take his nebulizers back to back but I never got started..."

Observations in Resident #29's room on 3/7/13 at 1:30 PM, revealed Resident #29 administering his own nebulizer treatment and there was no nurse in the room.

During an interview on the 2nd floor on 3/7/13 at 1:35 PM, Nurse #1 was asked if Resident #29 was self administering his nebulizer treatment. Nurse #1 stated, "No ma'am. I was trying to stay close so I could hear him. I just had to go down the hall to do something else..."

During an interview in the Director of Nursing's (DON) office on 3/7/13 at 1:40 PM, the DON was asked if there were any residents in the facility that self administered medications. The DON stated, "No, the nurses are suppose to stay at the..."
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<th>COMPLETION DATE</th>
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<tr>
<td>F 176</td>
<td>Continued From page 5 bedside until they finish their meds [medications] whether it is a nebulizer, pill or whatever, they [nurses] are not to leave the room...&quot;</td>
<td>F 176</td>
<td>The facility has developed policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This policy includes review of reference checks prior to employment of any individual.</td>
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<tr>
<td>F 226</td>
<td>483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES</td>
<td>F 226</td>
<td>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</td>
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<td>This REQUIREMENT is not met as evidenced by: Based on policy review, review of employee personnel files and interview, it was determined the facility failed to implement the abuse prevention policy and procedure for pre-employment reference checks for 1 of 7 (Employee #5) employee personnel files reviewed.</td>
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<td>The findings included: Review of the facility's abuse prevention policy and procedure documented, &quot;...Pre - Employment Screening - When a potential new employee is considered for hire, each of the following steps should be taken to assure that the applicant is suitable for hire... Reference check(s) of the candidate's prior employment must be conducted by the department director, or designee, hiring candidate...&quot;</td>
<td></td>
<td>Review of Employee #5's (Certified Nursing Assistant) personnel file revealed there were no reference checks done with a hire date of</td>
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* FORM CMS-2587(02-06) Previous Versions Obsolete Event ID: 0H9K211 Facility ID: TN5703 If continuation sheet Page 6 of 29
F 226 Continued From page 6 9/28/12.

During an interview in the business office on 3/7/13 at 9:06 AM, the Human Resource Manager (HRM) was asked who checked references for potential employees. The HRM stated, "If they are in the nursing department then nursing management does the reference checks..."

During an interview in the conference room on 3/7/13 at 11:05 AM, the Medical Records Nurse was asked who was responsible for reference checks. The Medical Records Nurse stated, "They should have been done by [Named former Director of Nursing (DON)]. She [former DON] was the DON when he [Employee #5] was hired..." The Medical Record Nurse verified that Employee #5's reference checks were not done until 3/7/13.

During an interview in the Administrator's office on 3/7/13 at 10:00 AM, the Administrator verified that the reference checks for Employee #5 were not done until 3/7/13. The Administrator stated, "I know we don't have it [reference check for Employee #5] we have to do it..."

F 278 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the

F 226 The Human Resources Manager will present the result of the weekly audit to the Quality Assurance/ Performance Improvement Committee monthly for three months and/or substantial compliance is achieved. The Quality Assurance/ Performance Improvement Committee include the Administrator, Director of Nursing, Admissions/ Social Services Director, Activities, Rehabilitation Director, Maintenance, Dietary Manager, and Medical Director.

F 278 The facility will ensure the Minimum Data Set (MDS) is accurate for all residents.

The MDS nurse completed a modified correction for Resident #20 and Resident #46 on 03/18/13 and submitted to CMS on 03/19/13.
P 278. Continued From page 7
assessment is completed.

Each individual who completes a portion of the
assessment must sign and certify the accuracy of
that portion of the assessment.

Under Medicare and Medicaid, an individual who
willfully and knowingly certifies a material and
false statement in a resident assessment is
subject to a civil money penalty of not more
than $1,000 for each assessment; or an individual
who willfully and knowingly causes another Individual
to certify a material and false statement in a
resident assessment is subject to a civil money
penalty of not more than $5,000 for each
assessment.

Clinical disagreement does not constitute a
material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it
was determined the facility failed to ensure the
minimum data set (MDS) was accurate for
diagnoses for 2 of 20 (Residents #20 and 46) of
the 32 sampled residents included in the stage 2 review.

The findings included:

1. Medical record review for Resident #20
documented an admission date of 2/13/13 with
diagnoses of Diabetes, Dementia with Behavior
Disturbances, Anxiety, Esophageal Reflux,
Peripheral Neuropathy, Depression, Paranoid
State, Coronary Artery Disease, Hepatitis C,
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<td>F278</td>
<td>Continued From page 8</td>
<td>Hyperlipidemia, Osteoarthritis, Encephalopathy, History of Stroke, History of Percutaneous Endoscopic Tube (PEG) Tube Placement and Removal, History of Cerebral Vascular Accident (CVA), Seizure Disorder, Schizoaffective Disorder, Leukopenia, Protein Malnutrition, and Constipation. Resident #20's admission MDS dated 2/20/13 in section I did not document the diagnoses of Hepatitis C, Anxiety, Hyperlipidemia, Schizoaffective Disorder, Paroxysmal State, Coronary Artery Disease, Osteoarthritis and Constipation. During an interview on the 100 hall on 3/6/13 at 4:43 PM, Licensed Practical Nurse (LPN) #4 was asked about diagnoses and caring for Resident #20. LPN #4 stated, &quot;I would watch for her [Resident #20] mood... diabetes... she has problems with blood sugar... she ambulatory... gait is steady... stays in room most of the time... she is quiet... she has an old peg [percutaneous endoscopy gastrostomy] site that I make sure to keep clean.&quot; LPN #4 was asked if she was aware of the Resident's diagnosis of Hepatitis C. LPN #4 stated, &quot;No, I wasn't.&quot; LPN #4 was asked if she was aware that Hepatitis C is a diagnosis in Resident #20's medical record. LPN #4 stated, &quot;No.&quot;</td>
<td>F278</td>
<td>The MDS Coordinator will present the result of the weekly audit to the Quality Assurance/Performance Improvement Committee monthly for three months and/or substantial compliance is achieved. The Quality Assurance/Performance Improvement Committee include the Administrator, Director of Nursing, Admissions/ Social Services Director, Activities, Rehabilitation Director, Maintenance, Dietary Manager, and Medical Director.</td>
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F 278 Continued From page 9

control precautions. CNA #3 stated, "Not that I know of... charge nurse hasn't told me anything..."

During an interview in the MDS office on 3/6/13 at 4:55 PM, the MDS Coordinator was asked how she determined the diagnoses to be included on Resident #20's MDS. The MDS Coordinator stated, "I go through their history and physical from the admitting facility... look for skillable factor... enter diagnoses from that... I enter all the diagnoses I see... It would be in section I even if it was a diagnosis that wasn't active... I would consider Hepatitis C an active diagnosis... Hyperlipidemia would be an active diagnosis..."

2. Medical record review for Resident #46 documented an admission date of 10/25/09 with diagnoses of Hypothyroidism, Diabetes, Anemia, Hyperlipidemia, Dementia with Behavior Disturbances, Paranoid Schizophrenia, Psychosis with Delusions, Catatonic, Hypertension, History of Fall with Subdural Hematoma, Dermatitis, Osteoporosis, Failure to Thrive, Hypertension, Insomnia, Chronic Constipation, Seasonal Allergies, Gout, Secondary Parkinon's and Essential Tremors. The annual MDS dated 12/19/12 in section I active diagnoses did not document Resident #46's diagnoses of Osteoporosis, Parkinson's Disease, Essential Tremors, Insomnia, Constipation, Hyperlipidemia and Chronic Anemia.

F 280 483.20(d)(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

A comprehensive care plan will be developed within seven days of the MDS completion prepared by the Medical Director, Registered Nurse with Responsibility for the patient, and other appropriate staff in disciplines determined by the Resident's needs.

F 280

03/27/13
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<td>F 280</td>
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<td>F 280 The care plan for resident #20 for Hepatitis C was added to the Care Plan on 03/08/13 by the MDS coordinator. The weight loss for Resident #44 was added to the Care Plan on 03/08/13 as well as appropriate interventions. 100% of all patient care plans will be audited by the MDS Coordinator by 03/27/13 to ensure accuracy. The entire staff was in serviced on 03/11/13 regarding OSHA, blood borne pathogens, Safe injection practices, safe blood glucose monitoring practices, proper use of sharp containers, and treatment of all patients as their blood was infected with the use of Universal Precautions at all times. An in service was given by the Regional Nurse Consultant to the Dietary Manager, nurse management. And the MDS Coordinator on 03/19/13 with regard to ensuring that a proper care plan is in place for all potential problems the patient may have and that any and all interventions have been added as appropriate. The MDS coordinator will audit the care plans for accurate diagnoses and interventions on 2 resident's last MDS assessments weekly for 3 months or until 100% compliance is achieved.</td>
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<td>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, 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.</td>
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|     |           |     | 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 revise the comprehensive care plan to reflect the current status and diagnoses for 2 of 20 (Residents #20 and 44) of the 32 sampled residents included in the stage 2 review. The findings included: 1. Review of the facility's care planning - interdisciplinary team comprehensive policy documented, "An Individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident... A comprehensive care plan for each resident is developed within
F 280 Continued From page 11

twenty-one (21) days of completion of the resident admission. The care plan is based on the resident's comprehensive assessment and is developed by a care planning / interdisciplinary team... Prior to attending scheduled care planning conferences, each discipline will be responsible for developing a problem identification list... Each discipline will provide a written or oral report of the resident's problems, strengths, goals, and approaches... Care plans are revised as changes in the resident's condition dictate... The Care Planning / Interdisciplinary Team is responsible for the periodic review and updating of care plans: a. When there has been a significant change in the resident's condition; b. When the desired outcome is not met; c. Then the resident has been readmitted to the facility from a hospital stay; and d. At least quarterly..."

2. Medical record review for Resident #20 documented an admission date of 2/13/13 with diagnoses of Diabetes, Dementia with Behavior Disturbances, Anxiety, Esophageal Reflux, Peripheral Neuropathy, Depression, Paranoid Stale, Coronary Artery Disease, Hepatitis C, Hyperlipidemia, Osteoarthritits, Encephalopathy, History of Stroke, History of Percutaneous Endoscopic Tube (PEG) Tube Placement and Removal, History of Cerebral Vascular Accident (CVA), Seizure Disorder, Schizoaffective Disorder, Leukopenia, Protein Malnutrition, and Constipation. The comprehensive care plan dated 3/2/13 did not address the problem / diagnosis of Hepatitis C.

During an interview in the Minimum Data Set (MDS) office on 3/6/13 at 4:55 PM, the MDS Coordinator, stated, "I would consider Hepatitis C..."
| F 280 | Continued from page 12
|       | an active diagnoses... Yes... there should be a care plan... I am responsible for that..."

3. Medical record review for Resident #44 documented an admission date of 6/2/11 and a readmission date of 9/21/12 with diagnoses of Mental Disorder, Paranoid Schizophrenia, Anxiety, Emphysema, Cardiomegaly, Diverticula of Colon, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Bilateral Prostate Hypertrophy, and Dementia with Behavior. The monthly weight form documented a significant weight loss of 7.5 percent (%) from 12/27/12 at 200 pounds, 1/9/13 at 190 pounds, to 2/8/13 at 185 pounds. Physician's orders documented the following interventions: 1/11/13 speech therapy for dysphagia, 1/23/13 diet change to pureed, 2/1/13 super cereal at breakfast, and 2/18/13 calorie count and laboratory tests. The care plan dated 2/20/14 did not address the significant weight loss and interventions that had been put in place for the weight loss.

Observations in Resident #44's room on 3/7/13 at 7:45 AM, Resident #44 was sitting up in his recliner he had just completed the breakfast meal and had consumed 100% of the meal.

During an interview at the nurses station on 3/7/13 at 3:00 PM, Certified Nursing Assistant #2 stated, "He [Resident #44] feeds himself after we set the tray up, he eats real good."

| F 309 | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
|       | Each resident must receive and the facility must provide the necessary care and services to attain
Continued From page 13

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 policy review, medical record review, observation and interview, it was determined the facility failed to provide necessary care and services by not following physician's orders for pain medication administration for 1 of 1 (Resident #45) sampled residents with pain reviewed of the 32 residents included in the stage 2 review. The failure to administer pain medication as ordered resulted in actual harm to Resident #45 when the resident experienced increased agitation.

The findings included:

Review of the facility's medication administration general guidelines policy documented, "...If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time... the space provided on the front of the MAR [medication administration record] for that dosage administration is initialed and circled..."

Review of the facility's "Pain Management" policy documented, "...Any resident who experiences pain will be reviewed and a plan will be established to treat his or her pain... Chronic pain is pain that is persistent or recurrent... In the long-term care setting, the comfort and well-being

Each resident will receive and the facility will 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.

A pain assessment was completed on Resident #45 on 03/07/13. Resident received schedule pain medication on 03/07/13 and alternative non medication interventions that were effective. Resident #45 is assessed for pain at a minimum of every shift and pain is controlled with scheduled and/or PRN medication. The physician was notified and there were no new orders or additions to this residents’ treatment plan. The nurses were in services to administer resident #45 PRN Loratab for breakthrough pain.

100% of residents were assessed for pain on 03/07/13. Two additional residents expressed pain and pain medication was administered and effective.
**NAME OF PROVIDER OR SUPPLIER**
LAURELWOOD HEALTHCARE CENTER

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<td>F 309</td>
<td>Continued From page 14 of the individual resident should always be paramount... Medications used to treat chronic pain should be given by the clock, on a regularly scheduled basis...</td>
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<td>Medical record review for Resident #45 documented an admission date of 9/11/09 and a readmission date of 8/11/12 with diagnoses of Vascular Dementia with Delusions, Anemia, Hypothyroidism, Personality Disorder, Benign Prostatic Hypertrophy with Urinary Obstruction, Hypertension, Ostearthrosis, Depressive Disorder, Muscle Weakness, Hypothyroidism, Bipolar Disorder, Neuropathy, Ischemic Heart Disease, Peripheral Vascular Disease and Esophageal Reflux Disease. Review of the Minimum Data Set (MDS) dated 1/23/13 documented, &quot;...section C0600 a BIMS [Brief Interview for Mental Status] Res [resident] Interview: summary score 3...&quot; A score of 0 to (-) 7 indicates severe impairment for cognition. Review of section J0300 documented the resident has pain; section J0400 documented a &quot;frequency 1&quot; indicating pain is almost constant and section J0600A indicated pain makes it hard for resident to sleep and section J0600B indicated the pain is moderate. Review of a physician's order dated 8/2/12 documented, &quot;...CELEBREX 100MG CAPSULE TAKE 1 CAPSULE BY MOUTH 2 TIMES DAILY (ARTHHRITIS)...&quot; Review of the physician's order dated 10/18/12 documented, &quot;...MS CONTIN 15MG [milligrams]... MORPHINE ER [extended release] 16 MG TABLET TAKE 1 TABLET BY MOUTH 2 TIMES DAILY (PAIN)...&quot; Review of physician's order dated 11/21/12 documented, &quot;...MS CONTIN 30 MG TABLET MORPHINE...&quot;</td>
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**Statement of Deficiencies and Plan of Correction**

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<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 309</td>
<td>Continued From page 15</td>
<td>SULF [sulfate] ER 30MG TAB TAKE 1 TABLET BY MOUTH 2 TIMES DAILY (CHRONIC PAIN)...</td>
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<td>Review of a physician's telephone order dated 12/24/12 documented, &quot;...MS Contin 30 mg 1 PO [by mouth] BID [twice a day] @ [at] 9a [am] &amp; [and] 9p [pm] for chronic pain...&quot;</td>
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<td>Review of the facility's physician progress notes documented the following:</td>
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<td></td>
<td></td>
<td>a. 11/20/12 - &quot;...still having significant leg pain...&quot;</td>
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<td></td>
<td></td>
<td>b. 12/13/12 - &quot;leg pain/PVD [peripheral vascular disease], leg still hurts... PVD [sign for with] PAD [peripheral arterial disease]...&quot;</td>
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<tr>
<td></td>
<td></td>
<td>c. 3/6/13 - &quot;...Chronic leg pain [sign for secondary to] PAD...&quot;</td>
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<td>Review of the January 2013 MAR revealed circles around initials (indicating medication not given) on the mornings of 1/28/13 and 1/29/13 and at 6 AM and a blank space in the 6 PM spot. The back of the MAR on the nurses' medication notes dated 1/28/13 at 6 AM documented, &quot;...Celebrex 100mg 1 medication N/A [not available] due from pharmacy... 1/29/13 6 A Celebrex 100mg 1 medication N/A due from pharmacy...&quot; The Celebrex was not given due to not being available.</td>
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<td>Review of the February 2013 MAR for 2/1/13 through (-) 2/28/13 revealed no documentation that Resident #45 had received MS Contin 30 mg at 9:00 AM on 2/28/13 and there was no documentation on the back of the MAR why the resident did not receive the medication.</td>
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<td>Review of the nurses notes dated 2/28/13 at 8:44 PM documented, &quot;...resident showed some signs of agitation earlier in the shift, but was able to...&quot;</td>
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</tbody>
</table>
Continued From page 16
redirect and talk him down. But he also has not had his morphine for at least 2 days and the pharmacy did not bring it again tonight. He started showing more signs of agitation around 8 PM, so I went ahead and gave his PRN [as needed] Ativan shot hoping to calm the agitation and limit the possible withdrawals. Pharmacy cannot be called right now, because they are not business hours, so they will need to be called in the morning about why he hasn't got his morphine. Will watch for signs of withdrawal or increased pain...

Review of the care plan dated 2/12/13 documented, "...Risk for anxiety, agitation, depression, insomnia, aggression R/T [related to] vascular dementia with delusions; BLE [Bilateral Lower Extremity] PAIN for which complete relief is not achieved..." The documented interventions included "...administer pain meds as ordered..." Revisions of the care plan dated 2/25/13 documented, "...Resident has [sign for increased anxiety poss [possible] R/T pain... 2/27/13 Med [medication] [sign for changes]... Meds as ordered..."


Review of the facility's narcotic count sheet II documented, on lines 10 and 11 to "...REORDER NOW!!!" The facility did not reorder the medication for Resident #45 to ensure the medication was available for administration.

Review of the facility's medication delivery receipt
F 309  Continued From page 17
documented, 30 tablets of Morphine ER were
ordered on 2/28/13 by the facility staff and
received on 3/1/13.

During an interview in the conference room on
3/6/13 at 3:30 PM, Nurse #3 was asked about the
documentation in the nurses notes dated 2/28/13.
Nurse #3 stated, "He [Resident #45] didn't have it
[MS Contin] the night of the 27th and the 28th
morning. I forgot to circle it." Nurse #3 was asked
if the initials on the MAR on the 27th were his.
Nurse #3 stated, "Yes, it is..." Nurse #3 was
asked who initialed the medication administration
record the next morning and circled it. Nurse #3
stated, "[Named Nurse #1]."

During an interview in the medication room on
3/6/13 at 3:45 PM, the Director of Nursing (DON)
and the Assistant Director of Nursing (ADON)
were asked if Morphine is available in the lock
box for after hour use. The DON and the ADON
stated, "We have Morphine IM [Intramuscular] in
the box. We have 10 milligrams and 20
milligrams, not po [by mouth] tablets only
suspension in the lock box..."

During an interview in the conference room on
3/6/13 the nurse consultant stated, "He [Nurse
#3] made a mistake on that documentation..."

During an interview in the conference room on
3/6/13 at 5:00 PM, the Nurse Consultant stated, "I
am going to let you look at it [the narcotic sign out
sheet] and figure it out. I can't tell anything about
it. I will let you look at it and ask me questions..."
The Nurse Consultant was then asked if Resident
#45 received the MS Contin on January 27th or
29th or Celebrex on January 29th or 29th [2013].
The Nurse consultant stated, "No, he didn't get the MS Contin on January 27th or 28th nor the Celebrex on January 28th or 29th..." The Nurse Consultant was then asked what it means when the initials of the nurse are circled. The Nurse Consultant stated, "When it is circled, as a nurse, I know they [resident] didn't get it..."

During an interview in the conference room on 3/6/13 at 4:10 PM, the DON stated, "We have a back up pharmacy, I think it is [Named Pharmacy] we can call after hours, they will deliver it or put it in a cooler and send it... he [Nurse #3] should have called the pharmacy, the doctor and faxed the order to the backup pharmacy..." The DON stated, "The medication was delivered after midnight on the 28th so it was delivered on 3/1/13..."

During an interview in the conference room on 3/5/13 at 5:55 PM, the DON stated, "It wasn't here the evening of the 27th [2/27/13] and morning and evening of the 28th [2/28/13] and [Named Nurse #3] called the evening of the 28th [2/28/13] and the med was delivered after midnight the 28th [2/28/13] and it was signed for on 3/1/13..."

During an telephone interview on 3/7/13 beginning at 8:05 AM, the Pharmacist stated, "Nurses responsibility to order medication before they run out... they should still have a couple of days left..." The Pharmacist confirmed the pharmacy will not send medication refills until the count sheet is received from the facility.

The failure to administer pain medication as ordered resulted in actual harm to Resident #45
Continued From page 19
when the resident experienced increased agitation.

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 2 (Nurse #1) nurses administered medications with a medication error rate of less than five percent (%). A total of 2 medication errors were observed out of 38 opportunities for error, resulting in a medication error rate of 5.26315%.

The Findings included:
Review of the facility’s medication administration general guidelines policy documented, "Medications are administered as prescribed... Medications are administered in accordance with written orders of the attending physician... The resident is always observed after administration to ensure that the dose was completely ingested. If only a partial dose was ingested, this is noted on the MAR [Medication Administration Record], and action is taken as appropriate."

Medical record for Resident #29 documented an admission date of 11/27/06 with a readmission date of 6/27/11 with diagnoses of Hypertension, Anemia, Chronic Airway Obstruction, Aphasia

The facility will ensure that it is free of medication error rates of five percent or greater.

The physician was notified regarding errors for resident #29. There were no new orders. The resident was monitored with no adverse effects.

There were no other medication errors. No other residents were affected.

Nurse #1 was reeducated on 03/11/13 by Assistant Director of Nursing and was able to demonstrate 100% competency. All nurses were informed on medication administration policy on 03/11/13 by Assistant Director of Nursing including 5 R's of administration. All nurses were reassessed for competency related to medication administration by 03/22/13 by Director of Nursing, Assistant Director of Nursing's, and Staffing Coordinator.

Any nurse with less than 100% compliance was retrained and reassessed until he/she proved 100% compliance. Nurses will be reassessed for medication administration competency by Director of Nursing or designee monthly for three months to ensure ongoing compliance and annually thereafter.
**F 332** Continued From page 20
and Late Effect Cerebral Vascular Disease, Schizophrenia and Hyperlipidemia. Review of a physician's orders dated 3/4/13 documented, "...GUAIFENESIN 100MG [milligrams] / [per] 5ML [milliliters]... TAKE 5ML... BY MOUTH 3 TIMES DAILY... POLYETHYLENE GLYCOL 350 MIX 17Gm [grams]... IN 8OZ [ounces] WATER/JUICE AND TAKE BY MOUTH EVERY MORNING..."

Observations in Resident #29's room on 3/7/13 at 9:13 AM, Nurse #1 administered Robafen DM (Guaifenesin 100 milligrams (mg) and Dextromethorphan 10mg) to Resident #29. Nurse #1 administered Polyehtylene Glycol in 4 ounces of water without stirring the medication to mix with the water to Resident #29. Medication residue was left in the bottom of the cup. Nurse #1 discarded the cup with medication residue in the trash. The failure to administer Guaifenesin 100mg/5ml resulted in medication error #1. The failure to administer the complete dose of Polyehtylene Glycol and the failure to administer Polyehtylene Glycol in 8oz of water resulted in medication error #2.

During an interview in the medication storage room on 3/7/13 at 2:45 PM, Nurse #1 was asked how many ounces of water the Polyehtylene Glycol administered to Resident #29 was mixed with. Nurse #1 stated, "4 ounces... I used the wrong size cup... it should have been 8 ounces..." Nurse #1 was then asked if Resident #29 received all the Polyehtylene Glycol from the cup. Nurse #1 stated, "There was some [medication residue] left in the bottom that didn't come out..." Nurse #1 was asked what Guaifenesin was given to Resident #29. Nurse #1 stated, "...Robafen DM... It's the only one that's..."
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
LAURELWOOD HEALTHCARE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**
200 BIRCH ST
JACKSON, TN 38301

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEG IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 332</td>
<td>Continued From page 21 on here [medication cart]. The order says Guainol... not DM...</td>
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<td>F 364</td>
<td>SS=D</td>
<td>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</td>
<td>Each resident receives and the facility will provide food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This food was not served to residents, therefore no resident was affected.</td>
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<tr>
<td>F 334</td>
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<td></td>
<td>Each resident receives and the facility will provide food prepared by methods to conserve nutritive value, flavor, and appearance; and food that is palatable attractive, and at the proper temperature. This food was not served to residents, therefore no resident was affected.</td>
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**Observations in the kitchen on 3/6/13 beginning at 10:35 AM, Dietary staff member #1 was serving meals to the staff member.**

**Observations in the kitchen on 3/6/13 beginning at 10:35 AM, Dietary staff member #2 (the cook) calibrated the thermometer and took food temperatures. The temperature of the turkey was 160 degrees Fahrenheit (F), dressing 156 degrees F and pureed turkey 154 degrees F.**

**During an interview in the kitchen, Dietary staff**
F 364: Continued From page 22
member #2 was asked what was the acceptable temperature for turkey and dressing. Dietary staff member #2 stated, "I done forgot."

During an interview in the kitchen on 3/6/13 at 1:05 AM, Dietary staff member #2 was asked how many plates had been served and sent out. Dietary staff #2 stated, "Four." Did you recheck the food temperature before it was served? Dietary staff member #2 stated, "No, I didn't..."

During an interview in the kitchen on 3/5/13 at 10:35 AM, the Certified Dietary Manager (CDM) was asked what was an acceptable temperature for the turkey and dressing. The CDM stated, "165 on up."

During an interview in the kitchen on 3/6/13 at 10:45 AM, the Registered Dietitian was asked when the food temperatures should be taken. The RD stated, "They [staff] should temp [food] before serving..."

F 371 483.35(i) FOOD PROCURE, 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:

F 364: The Dietary Manager will present the result of the weekly audit to the Quality Assurance/ Performance improvement Committee monthly for three months and/or substantial compliance is achieved. The Quality Assurance/ Performance Improvement Committee include the Administrator, Director of Nursing, Admissions/ Social Services Director, Activities, Rehabilitation Director, Maintenance, Dietary Manager, and Medical Director.

F 371: The facility will store, prepare, distribute, and serve food under sanitary conditions.

The snacks were disposed of and not distributed therefore no resident was affected. Dietary Manager inspected department to insure there were no other predated labels.
Continued From page 23

Based on policy review, observation and interview, it was determined the facility failed to ensure food was stored, prepared and distributed under sanitary conditions as evidenced by sandwiches improperly dated.

The findings included:

1. Review of the facility’s "FOOD STORAGE" policy documented, "...All products should be dated upon receipt and when they are prepared..."

Observations in the kitchen walk in refrigerator on 3/5/13 at 8:20 AM, revealed 3 trays of resident snacks with 7 and 1/2 sandwiches prepared for the residents dated 2/28/13.

During an interview in the walk in refrigerator on 3/5/12 at 8:20 AM, the Certified Dietary Manager (CDM) was asked if the date on the label was when the sandwiches were prepared. The CDM did not reply.

During an interview in the kitchen on 3/6/13 at 7:50 AM, Dietary staff member #3 was asked how long snacks are good once prepared. Dietary staff #3 stated, "Are you talking about those sandwiches yesterday? They were prepared yesterday, the date was wrong. We just made copies of the label she already had made..."

Dietary staff #3 was asked what the date on the label is intended for. Dietary staff #3 stated, "The date they are prepared..." Dietary staff #3 was asked what do you do with the sandwiches if they go out to the residents and they are returned to the kitchen? Dietary staff #3 stated, "They get thrown out." Dietary staff #3 was asked what do

The Registered Dietitian in serviced Dietary staff on 03/03/13 regarding the correct procedure for preparing, labeling, and dating snacks. All Dietary and Nursing staff were in serviced on labeling and dating food including snacks on 03/11/13 by Administrator. Nursing was in serviced to ensure snacks were no more than 24 hours old when accepting snack trays and return them to Dietary if date is not within twenty four hours. Dietary will not prepare labels in advance. Snacks will not be prepared more than twenty four hours before serving time. The Dietary Manager will monitor snack preparation and distribution at least three times weekly for eight weeks. The Director of Nursing or designee will monitor distribution of snacks at least two times weekly times 8 weeks.

The Dietary Manager will present the result of the weekly audit to the Quality Assurance/Performance Improvement Committee monthly for three months and/or substantial compliance is achieved. The Quality Assurance/Performance Improvement Committee include the Administrator, Director of Nursing, Admissions/ Social Services Director, Activities, Rehabilitation Director, Maintenance, Dietary Manager, and Medical Director.
F 371  Continued From page 24
   you do with leftover foods after they are opened
   or prepared and left over Dietary staff #3 stated
   "Keep 2 days and throw it out..."

   During an interview in the hall beside the
   conference room on 3/6/13 at 8:20 AM, the
   Certified Dietary Manager (CDM) was asked if the
   date on the label applied to the snacks is the date
   the food is prepared. The CDM stated, "Yes,
   ma'am." The CDM was then asked about the
   date on the sandwich on the tray in the
   refrigerator on the day before. The CDM stated,
   "Yes, It was the wrong date on the label..." The
   CDM was asked who makes the label? The CDM
   stated, "I do."

   2. Observations on the 200 hall on 3/6/13 at
   10:15 AM, revealed staff members passing out
   snacks to the residents.

   During an interview in the 200 hall on 3/6/13 at
   10:15 AM, Certified Nursing Assistant (CNA) #1
   was asked do you look at the date on the snack
   sandwiches. CNA #1 stated, "To be truthful I
   never have before today..." CNA #1 was asked
   what would you do if the date was other than
   today's date. CNA #1 stated, "Return it to the
   kitchen..." CNA #1 was asked why would you just
   look at the date today? CNA #1 stated, "Cause
   you just asked about it."

F 425  483.30(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(n) of this part. The facility may permit
   unlicensed personnel to administer drugs if State
<table>
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<tr>
<th>F 425</th>
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<tr>
<td>law permits, but only under the general supervision of a licensed nurse.</td>
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<tr>
<td>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologics) to meet the needs of each resident.</td>
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<tr>
<td>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.</td>
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<tr>
<td>F 425</td>
<td>The physician was notified for resident #29 &amp; #45. There were no changes to resident #29 and #45 treatment plans. Resident #29 was monitored for adverse effects and none was noted. The physician was notified for resident #29 with no new orders. Resident #45 was reassessed for pain on 03/07/13 and was administered scheduled pain medication and alternative non-medication intervention. These interventions were effective for resident #45.</td>
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<tr>
<td>An audit of the medication was conducted 3/22/13 to determine if medications were available for administration as ordered by the physician. No other resident's have been affected.</td>
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**FORM CMS-2587(02-99) Previous Versions Obsolete**

**Event ID: 9142211**

**Facility ID: THS703**

**If continuation sheet Page 26 of 29**
F 425 Continued From page 26
and Late Effect Cerebrovascular Disease, Schizophrenia and Hyperlipidemia, Review of a physician's orders dated 3/4/13 documented, "...PACERONE 200MG [milligrams] TABLET... TAKE 1 TABLET BY MOUTH DAILY..."

Review of the March 2013 Medication Administration Record (MAR) for Resident #29 revealed, the 8 AM dose of Pacerone 200 mg for 3/7/13 was initialed and circled by Nurse #11; Indicating the medication was not given.

Observations in Resident #29's room on 3/7/13 at 9:13 AM, Nurse #1 did not administer the 8 AM dose of Pacerone 200 mg as ordered by the physician.

During an interview at the nurses' station on 3/7/13 at 11:15 AM, Nurse #2 stated, "The pharmacy consultant comes on Sundays and checks the medication storage..."

During an interview in the medication storage room on 3/7/13 at 2:45 PM, Nurse #1 was asked what the circled initials on Resident #29's MAR meant and if the Pacerone was administered to Resident #29 as ordered. Nurse #1 stated, "That circled initials means it wasn't given... he [Resident #29] didn't have any [Pacerone 200 mg]." Nurse #1 was asked if the pharmacy automatically supplies medications monthly for residents. Nurse #1 stated, "No. The nurses have to order it [medication] when they need it..."

2. Medical record review for Resident #45 documented an admission date of 9/11/09 and a readmission date of 8/1/12 with diagnoses of Anemia, Vascular Dementia with Delusions,

A new system has been put into place to ensure nurses check medication carts on a daily basis to ensure all necessary medications are available. The Director of Nursing or designee will audit medication/treatment carts at least three times weekly for two months or until 100% compliance is obtained. Nurses were in serviced on this new system on 03/08/13 and 09/11/13. The pharmacy has been notified on 03/08/13 that they must provide medication refills and new orders in a timely manner. Nurses will be in serviced on 03/25/13 by Director of Nursing regarding twenty four hour availability of medications from backup pharmacy.

The Director of Nursing will present the result of the weekly audit to the Quality Assurance/ Performance Improvement Committee monthly for three months and/or substantial compliance is achieved. The Quality Assurance/ Performance Improvement Committee include the Administrator, Director of Nursing, Admissions/ Social Services Director, Activities, Rehabilitation Director, Maintenance, Dietary Manager, and Medical Director.
F 425  Continued From page 27

Hypothyroidism, Personality Disorder, Benign Prostatic Hypertrophy with Urinary Obstruction, Hypertension, Osteoarthritis, Depressive Disorder, Muscle Weakness, Bipolar Disorder, Hypothyroidism, Neuropathy, Ischemic Heart Disease, Peripheral Vascular Disease and Esophageal Reflux Disease. Review of a physician's order dated 8/2/12 documented, "...CELEBREX 100MG CAPSULE TAKE 1 CAPSULE BY MOUTH 2 TIMES DAILY (ARTHRITIS)..."

Review of the January 2013 Medication Administration Record (MAR) documented initials with circles around the initials on the mornings of 1/28/13 and 1/29/13 at 5 AM and a blank space in the 6 PM spot. The back of the MAR on the nurses' medication notes dated 1/28/13 for 6 AM documented, "...Celebrex 100mg 1 medication N/A [not available] due from pharmacy... 1/29/13 6 AM Celebrex 100mg 1 medication N/A due from pharmacy..." The medication was not administered on those dates noted above.

Review of the care plan dated 2/12/13 documented, ",...Risk for anxiety, agitation, depression, insomnia, aggression R/T [related to] vascular dementia with delusions; BLE [Bilateral Lower Extremity] PAIN for which complete relief is not achieved," The documented interventions included "...administer pain meds as ordered..." Revisions of the care plan dated 2/25/13 documented, "...Resident has [sign for increased anxiety poss [possible] R/T pain... 2/27/13 Med [medication] [sign for changes]... Meds as ordered..."

Review of the facility's pain assessment sheet
Continued From page 28

dated February 2013 revealed no documentation for pain assessment on the 11-7 shift or 3-11 shift on 2/28/13.

During an interview in the conference room on 3/6/13 at 5:00 PM, the nurse consultant stated, "I am going to let you look at it [the narcotic sign out sheet] and figure it out. I can't tell anything about it. I will let you look at it and ask me questions..."
The Nurse Consultant was then asked if the resident [Resident #45] received the Celebrex on January 28th or 29th. The Nurse Consultant stated, "No, he didn't get the Celebrex on January 28th or 29th..." The Nurse Consultant was then asked what it means when the initials of the nurse are circled. The Nurse Consultant stated, "When it is circled, as a nurse, I know they [resident] didn't get it [medication]..."