TENNESSEE STATE VETERANS HOME

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<th>INITIAL COMMENTS</th>
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|       | An annual re-certification survey and complaint investigation for TN00022880 were conducted on 8/3/09 through 8/12/09. An entrance conference with the Director of Nursing and Compliance Nurse was conducted in the conference room on 8/3/09 at 9:10 AM.
|       | An exit conference was held with the Interim Executive Director, Interim Administrator, Director of Nursing, Regional Compliance Nurse, Regional Reimbursement Nurse and the Certified Dietary Manager, in the conference room, on 8/12/09 at 11:20 AM, to inform them of the surveyors findings that placed residents in immediate jeopardy. The staff failed to administer insulin as ordered, obtain blood sugars as ordered and failed to notify the physician of blood sugars below 60 and/or above 401, placing all diabetic residents in immediate jeopardy. The immediate jeopardy existed from 7/29/09 to 8/12/09. The immediate jeopardy was abated as of 8/12/09 after receiving an acceptable creditable allegation. |

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<th>F 157</th>
<th>NOTIFICATION OF CHANGES</th>
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| 483.10(b)(11) | A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse

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| neither believes nor admits that any deficiencies existed before, during or after the survey reflected herein. Tennessee State Veterans Home reserves all rights to contest the survey findings through Informal Dispute Resolution or formal appeal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position. Nothing in the plan of correction should be construed as admission of guilt or considered a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which Tennessee State Veterans Home does not waive and reserves the right to assert in any civil, administrative or criminal claim, action or proceeding Tennessee State Veterans Home its response, credible allegations of compliance and plan of correction as part of its on-going efforts to provide quality of care to its Residents.

LABORATORY DIRECTOR'S OR PROVIDER/SUSTAINER REPRESENTATIVE'S SIGNATURE 8/25/09

|Facility ID: TN2708| Event ID: QTSX11| Form ID: 2587(02-99)| Previous Versions Obsolete| If continuation sheet Page 1 of 77|

All deficiency statements ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined 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 these documents are made available to the facility. If deficiencies are cited, an appropriate plan of correction is required to continued program participation.

RECONCIL.

AUG 25 2009
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDERS/ SUPPLIER/Clinical Laboratory Improvement Amendment Act (CLIA) IDENTIFICATION NUMBER:**

445366

**(X2) MULTIPLE CONSTRUCTION**

A. BUILDING

B. WING

**(X3) DATE SURVEY COMPLETED**

08/12/2009

**NAME OF PROVIDER OR SUPPLIER**

TENNESSEE STATE VETERANS HOME

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

2865 MAIN STREET

HUMBOLDT, TN 38343

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSQ IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<tr>
<td>F 157</td>
<td>Continued From page 1 consequences, or to commence a new form of treatment; or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident’s legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident’s legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on policy review, review of inservice records, medical record review, observations and interviews, it was determined the facility failed to ensure the physician was notified of low and elevated blood sugars (BS) for 3 of 30 Residents 12, 18 and 20) sampled diabetic residents. The failure to notify the physician of BS below 60 and above 401, placed all diabetic residents in immediate jeopardy. The immediate jeopardy began 7/29/09. The facility remained out of compliance at a scope and severity level &quot;D&quot; (an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure that the policies and procedures and training implemented by the facility could be reviewed by the Quality Assurance (QA) Committee.</td>
<td>F 157</td>
<td>1. Residents # 12,18, and 20 Blood sugar flow sheets were reviewed by the Director of Nurses and members of the Nursing Management Staff. The corresponding Physicians were notified of any glucose levels that were out of the stated parameters. 2. All Residents with an order for finger stick blood sugars have the potential to be affected. The Director of Nurses and members of the Nursing Management team reviewed all medical records of Residents with finger stick blood sugars ordered to ensure that the attending Physician had been notified of finger stick blood sugars that were outside the prescribed parameters.</td>
<td>08-06-09</td>
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**FORM CMS-2587(02-99) Previous Versions Obsolete**

Event ID: QTSX11 Facility ID: TN2759

If continuation sheet Page 2 of 77
3. All Residents who are prescribed finger stick blood sugars have the potential to be affected. The Admissions Coordinator will alert the Director of Nurses of all new Diabetic admissions, regardless of type of Diabetes. The Admissions Coordinator will keep a log of this notification. The Director of Nurses or designee will audit all newly admitted diabetics for the following:

- Order transcription accuracy
- Blood glucose checks/Insulin log accuracy
- Physician notification when blood glucose is outside the prescribed parameters

The records of newly admitted Diabetics will be audited at 100% for 3 months. The Director of Nurses or designee will report the findings to the Quality Improvement Committee for review. The Quality Improvement Committee will reserve the right to extend the
Continued From page 3

During an interview in the conference room on 8/5/09 at 2:30 PM, the Director of Nurses and the Regional Compliance Nurse were asked what the staff is supposed to use for sliding scale insulin. The Compliance Nurse stated, "...They [nurses] should go with what the order says, unless there's a clarification order to convert to the protocol, they should use the doctor's order...should have a standing order signed by [named medical director]...should be signed by all the doctors..."

2. During an interview in the conference room on 8/11/09 at 9:45 AM, the Regional Compliance Nurse stated that the Quality Assessment (QA) process started in March 2009. The Regional Compliance Nurse stated, "...That's when they [facility] started terminating people [failing to perform accuchek as prescribed, notifying physician of low and high blood sugars and administering insulin as ordered]...did group education...maybe we should do one-on-one..."

As a result of the QA findings in March 2009 the facility did a nursing inservice on 3/29/09 as follows: "...Topics...4. Accucheck & [and] Insulin Policy and Procedure...6. Physician and Family Notification...Accucheck and Insulin Policy and Procedure...1. Accucheck are to be performed as prescribed. The Accucheck will be documented on the Accucheck and Insulin flow sheet... If the Accucheck is below 80 or above 401 or as stated by the Physician, YOU MUST NOTIFY THE ATTENDING PHYSICIAN AND DOCUMENT. Document that the MD was notified and what the results of the notification are. FAILURE TO DO THIS WILL RESULT IN DISCIPLINARY ACTION LEADING VERY QUICKLY TO TERMINATION...Physician and Family Notification: 1. Licensed Nurses will notify..."
6. On 08-06-09, the Staff Development Nurse began an in-depth in-service for all Licensed Nurses regarding:

Diabetes and Insulin Administration:
- General diabetes discussion that included type 1 and 2 diabetes
- Lab values for diabetes
- Bedside glucose monitoring
- Oral Hypoglycemics and their actions
- Injectable medications to treat Diabetes
- Types of Insulin/side effects and actions
- Signs and symptoms of Hyperglycemia
- Signs and symptoms of Hypoglycemia
- Required documentation
- Factors that may affect glucose levels
- Actual administration of insulin products
- Facility Insulin Protocol
- Physician Notification
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/ SUPPLIER/ CLAUS IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
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<tbody>
<tr>
<td>445366</td>
<td>A. BUILDING</td>
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<td>B. WING</td>
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**8/12/2009**

**TENNESSEE STATE VETERANS HOME**

**STREET ADDRESS, CITY, STATE, ZIP CODE**
2665 MAIN STREET
HUMBOLDT, TN 38343

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<td>Review of the physician’s order initiated 2/10/09 and continued through 7/1/09 documented “...ACCUCHECKS BEFORE MEALS AND AT BEDTIME...6AM...11AM...4:30AM...8PM...SLIDING SCALE...150 - 200 = [amount of insulin to be administered] 2 UNITS...201 - 250 = 4 UNITS...251 - 300 = 6 UNITS...301 - 350 = 8 UNITS...351 - 400 = 10 UNITS...&gt;400 = 12 UNITS...”</td>
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<td>Review of Resident #20's May 2009 BS sheet documented 124 opportunities for a BS to be checked. The top of the May 2009 flow sheet for sliding scale insulin (SSI) documented &quot;...Call MD if BS &lt; 60 or &gt; 400 Chart on Back...&quot; There were 5 documented BS that were below 60 with no documentation of any intervention taken for the low BS, no documentation of monitoring of the resident, and no documentation that the physician was notified. The BS were as follows: a. 5/5/09 at 6:30 AM - BS was (=) 54. b. 5/8/09 at 6:30 AM - BS = 42. c. 5/8/09 at 6:30 AM - BS = 54. d. 5/8/09 at 6:30 AM - BS = 40. e. 5/22/09 at 6:30 AM - BS = 50. There were 6 documented BS that were above 400 with no documentation that the BS was rechecked, and no documentation that the physician was notified. The BS were as follows: a. 5/8/09 at 8:00 PM - BS = 413. b. 5/11/09 at 4:00 PM - BS = 430. c. 5/13/09 at 8:00 PM - BS = 404. o. 5/14/09 at 8:00 PM - BS = 434. f. 5/20/09 at 4:00 PM - BS = 460. g. 5/28/09 at 4:00 PM - BS = 405.</td>
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Review of Resident #20's June 2009 BS flow sheet documented 120 opportunities for BS to be
| F 157 Continued From page 6 checked. The top of the June 2009 flow sheet for SSI documented "...Call MD if BS < 60 or > 400 Chart on Back..." There were 3 documented BS that were below 60 with no documentation of any intervention taken to bring the BS up, no documentation of monitoring of the resident’s condition, and no documentation that the physician was notified. The BS were as follows:
  a. 6/5/09 at 6:30 AM - BS = 59.
  b. 6/5/09 at 11:00 AM - BS = 56.
  c. 6/6/09 at 5:00 PM - BS = 56, no BS obtained at 9:00 PM.

  There were 9 documented BS that were above 400 with no documentation that the BS were rechecked, and no documentation that the physician was notified. The BS were as follows:
  a. 6/4/09 at 9:00 PM - BS = 410.
  b. 6/10/09 at 5:00 PM - BS = 495.
  c. 6/11/09 at 9:00 PM - BS = 441.
  d. 6/14/09 at 5:00 PM - BS = 456, no BS obtained at 9:00 PM.
  e. 6/16/09 at 5:00 PM - BS = 407.
  f. 6/16/09 at 9:00 PM - BS = 434.
  g. 6/18/09 at 5:00 PM - BS = 405.
  h. 6/22/09 at 5:00 PM - BS = 500, no BS obtained at 9:00 PM.
  i. 6/30/09 at 5:00 PM - BS = 422.

  Review of Resident #20’s physician’s recertification orders dated 7/1/09 documented "...NOVOLIN R...9 UNITS SQ WITH LUNCH...NOVOLIN 70-30...22 UNITS...EVERY MORNING..." A telephone order dated 7/1/09 documented "...Give Regular insulin 6 units before supper... Cont. [continue] sliding scale insulin per protocol for accuchecks..." A telephone order dated 7/22/09 documented "...Increase morning 70/30 [insulin] to 32 units Continue insulin c [with] meals and basal insulin s
Continued from page 7

A telephone order dated 7/28/09 documented "... [change] Regular Insulin at Lunch and Dinner to 10 units... [change] SSI to Standard Sliding Scale... A telephone order dated 7/30/09 documented "...Cont. using standard sliding scale & [and] hold all scheduled insulins until further notice..." A telephone order dated 7/31/09 documented "...Insulin 70/30 32 units at breakfast... Lantus 8 units at bedtime... Hold above & scheduled insulin if pt [patient] does not eat... Regular insulin 9 units at lunch... Regular insulin 6 units at supper... Do accu [check] TID [three times a day]."

On 7/11/09 at 6:00 AM Resident #20's BS was 69. The resident was given 22 units of Novolin 70/30. There was no documentation that the resident ate anything, and no documentation of monitoring of the resident's condition. On 7/16/09 at 12:00 PM Resident #20's BS was 52 with no documentation of any intervention taken to bring the BS up, no documentation monitoring of the resident's condition, and no documentation that the physician was notified of the low BS.

Review of Resident #20's July 2009 BS flow sheet documented 6 BS that were above 400 with no documentation that the BS was rechecked, and no documentation that the physician was notified. The BS were as follows:

a. 7/5/09 at 4:45 PM - BS = 404.
b. 7/10/09 at 4:30 PM - BS = 441.
c. 7/13/09 at 4:00 PM - BS = 473.
d. 7/15/09 at 4:00 PM - BS = 429.
e. 7/18/09 at 4:00 PM - BS = 408.
f. 7/21/09 at 4:00 PM - BS = 403.

During a telephone interview with Resident #20's attending physician on 8/11/09 at 11:45 AM, the
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<td>MD stated &quot;...issues with the [BS] logs being completed... blanks... there is a system's problem...&quot;</td>
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<td>4. Medical record review for Resident #12 documented an admission date of 3/16/09 with diagnoses of Cerebral Vascular Accident, Bell's Palsy, Parkinson's, Seizure Disorder, Hypertension, Diabetes Mellitus, Hypoglycemia, Hyperlipidemia, Urinary Tract Infection, and Decubitus. Review of the physician's orders dated 7/5/09 documented &quot;NOVOLIN R 100 UNITS/ [per] ML [milliliters] AS DIRECTED ACCORDING TO SLIDING SCALE. ACCUCHECK TWICE DAILY SLIDING SCALE (REGULAR) BID [two times a day] BREAKFAST AND DINNER... &gt; 400 = 10 units &amp; [and] call MD...&quot;</td>
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<td>Review of Resident #12's Accuchek/Insulin Log for July 2009 documented on 7/10/09 at 4:30 PM blood sugar of 430. There was no documentation in the medical record that the physician was notified of the BS of 430.</td>
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<td>During an interview in the conference room on 8/5/08 at 6:55 PM, the Corporate Compliance Nurse was asked for documentation that the physician was notified of elevated blood sugars. The Corporate Compliance Nurse stated, &quot;I don't see it in the nursing note on 7/10/09, I will have them look at the 24 hour report.&quot;</td>
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<td>During an interview in the hall outside the conference room on 8/5/08 at 7:15 PM, the Corporate Compliance Nurse stated, &quot;He [Resident #12] is not on here [24 hour report for 7/10/09]. I don't see his [Resident #12] name.&quot; The Corporate Compliance Nurse verified that Resident #12's physician was not notified of the...&quot;</td>
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elevated blood sugar on 7/10/09.

5. Medical record review for Resident #18 documented an admission date of 7/18/07 with diagnoses of Organic Brain Syndrome, Diabetes Mellitus, Hypertension, and Hyperlipidemia.

Review of the physician's orders dated 7/5/09 documented, "ACCUCHECKS BEFORE MEALS... 6:30 AM... 11 AM, 4:30 PM... NOVOLIN R 100 UNITS/ML AS DIRECTED ACCORDING TO SLIDING SCALE. SLIDING SCALE (REGULAR) 60-100 = ORANGE JUICE 101-250 = NO INSULIN 201-250 = 4 UNITS 251-300 = 6 UNITS 301-400 = 8 UNITS 351-400 = 10 UNITS > 401 = NOTIFY MD..."

Observation during medication administration in Resident #18's room on 8/3/09 at 4:15 PM, revealed Nurse #10 administered Novolin R 12 units for a BS of 432 without notifying the physician and without an order for the insulin.

During an interview in the conference room on 8/5/09 at 2:40 PM, the DON stated, "...they [staff] document on the back of the blood sugar sheet [notification of MD]..."

6. During an interview in the conference room on 8/11/09 at 11:05 AM, Nurse #6 (a charge nurse working the day shift) was asked where the nurses were supposed to document if the MD was notified of BS < 60 or > 400. Nurse #6 stated, "...It would be on the back of those sheets [Accucheck/Insulin Logs]..."

During an interview in the conference room on 8/5/09 at 2:40 PM, the DON stated regarding MD notification of blood sugars of less than 60 and greater than 401, "They [Nurse] document [MD
7. The immediate jeopardy existed from 7/29/09 to 8/12/09.

On 8/12/09 the facility presented the survey team an acceptable allegation of compliance as follows:

a. On 8/5/09 the Staff Development Coordinator, conducted an inservice with all Licensed Nurses regarding insulin administration, facility policy and procedure for blood glucose checks, insulin protocol and physician notification of blood glucose below 60 and above 400. On 8/5/09 the facility Medical Director and two attending physicians re-approved the facility insulin protocol.

b. On 8/6/09 the attending physicians were notified of errors by the Management Nurses. On 8/6/09, the Staff Development Nurse began an in-depth inservice with all Licensed Nurses regarding Medication Administration and Diabetes and Insulin Administration. A re-education will take place within 3 months conducted by the Tennessee State Veterans Home University training system. Educational content was approved by the Medical Director. On 8/6/09 the facility Management Nurses began the process of clarifying/verifying all insulin orders for accuracy. 100 percent (%) of all residents had received clarification/verification by 8/7/09.

c. On 8/10/09 the facility Management Nurses began observing Licensed Nurses perform blood glucose checks and insulin administration.

d. On 8/11/09 a skills fair was conducted by the Staff Development Masters prepared Registered Nurse and sister facility Certified Diabetic Educator. The content included insulin...
TENNESSEE STATE VETERANS HOME

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<td>administration with return demonstration, physician notification, professional standards and facility policy for insulin administration and blood glucose checks with return demonstration.</td>
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<td>e. On 8/12/09, the Staff Development Coordinator re-educated all Licensed Nurses regarding professional standards of care.</td>
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<td>f. The Admissions Coordinator will alert the Director of Nurses of all new Diabetic admissions, regardless of type of Diabetes. A log will be kept of notification. The Director of Nurses or designee will audit all new admissions for order transcription accuracy, blood glucose checks/insulin log accuracy and physician notification when blood glucose is outside the prescribed parameters. Newly admitted Diabetics will be audited at 100 percent (%) for 3 months. The Director of Nurses or designee will report finding to Quality Improvement Committee for review. The committee will reserve the right to extend the auditing time frame.</td>
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<td>g. The Director of Nurses or designee(s) will audit 100% of all Diabetic medical records for accuracy and physician notification weekly times 4 then monthly for 3 months and report finding to Quality Improvement Team for review. The Regional Nurses will review at least 15 Diabetic medical records monthly and findings will be reported to the facility Administrator, Director of Nurses and Executive Director.</td>
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<td>h. Resident #20 was examined by the facility Medical Director and attending physician on 8/12/09. A plan of care was updated and agreed upon by facility Medical Director and attending physician.</td>
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<td>i. The Pharmacy Consultant will continue to perform monthly medication pass observations with emphasis on Insulin Administration. This will continue for 6 months or as needed.</td>
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F 157 Continued From page 12

j. The facility Compliance Nurse, Quality Improvement Nurse and Staff Development Coordinator will perform monthly medication pass reviews on alternating shifts for 3 months and then quarterly as part of an on-going Quality Improvement Plan. The results of the medication passes will be reported to the Quality Improvement Team for review.

After receiving the facility's acceptable allegation of compliance the surveyors verified that the corrective actions had been put in place to abate the immediate jeopardy. The surveyors verified the corrective actions by conducting an additional medication administration pass for observations of correct insulin administration and timely meal service, observed facility administrative staff monitoring nurses administering medications, reviewed inservice records and interviewed staff to verify the staff's knowledge of information received during the inservices. The immediate jeopardy was abated as of 8/12/09. The facility remains out of compliance at a scope and severity of "D".

F 164 483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY

The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this
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<td>F 164</td>
<td>Continued From page 13 section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</td>
<td>F 164</td>
<td>Tennessee State Veterans Home neither believes nor admits that any deficiencies existed before, during or after the survey reflected herein. Tennessee State Veterans Home reserves all rights to contest the survey findings through Informal Dispute Resolution or formal appeal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position. Nothing in this plan of correction should be construed as admission of guilt or considered a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which Tennessee State Veterans Home does not waive and reserves the right to assert in any civil, administrative or criminal claim, action or proceeding Tennessee State Veterans Home its response, credible allegations of compliance and plan of correction as part of its on-going efforts to provide quality of care to its Residents.</td>
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### F 164

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curtains or close blinds before administration of the insulin. Resident #12's abdomen was exposed to anyone who passed by.

2. Medical record review for Resident #19 documented an admission date of 7/9/09 with diagnoses of Cancer of Prostate with Bone Metastasis, Depression, Gout, Osteoarthritis, Diabetes, Seizures, Stroke, Peripheral Vascular Disease and Coronary Artery Disease.

Observations in Resident #19's room on 8/3/09 at 4:10 PM, revealed Nurse #3 administered 4 units of Novolog insulin SQ in Resident #19's right side of the abdomen. Nurse #3 did not pull the window blind, exposing Resident #19's abdomen to anyone who passed by.

3. Medical record review for Resident #20 documented an admission date of 2/10/09 with diagnoses of Alzheimer's, Dementia, Diabetes, Hyperlipidemia, Gastric Esophageal Reflux Disease and Urinary Tract Infection.

Observations in Resident #20's room on 8/3/09 at 2:20 PM, revealed the Director of Nursing (DON) did not knock before entering Resident #20's room, did not close door or pull the privacy curtain before administration of Intravenous medication.

Observations in Resident #20's room on 8/4/09 at 11:45 AM, revealed Nurse #6 administered 13 units of Novolin R Insulin SQ in Resident #20's abdomen. Nurse #6 did not close Resident #20's room door to hallway or close the blinds, exposing Resident #19's abdomen to anyone who passed by.

4. Medical record review for Resident #46

### Resident # 12,19, 20 and 46,
along with all facility Residents have the potential to be affected.

Regional Nurses or their designee made random observations of privacy during different times of the day, on different units with different staff members. The Regional Nurses or their designee documented the random observations and will present to the Quality Improvement Team for review. The Social Services Director will randomly audit staff to ensure they are knocking on doors before entering and that privacy is supplied during care. The audits will take place monthly for 3 months and the results of the audits will be reported to the Quality Improvement Team for review of findings.
F 164 Continued from page 15

documented an admission on 5/14/09 with
diagnoses of Pulmonary Embolism, Lumbago,
Organic Brain Syndrome, Hyperlipidemia, and
Diabetes Mellitus. Review of the physician's
order dated 7/8/09 documented an order for "...NOVOLIN N...20 UNITS SQ [subcutaneous]
...BEFORE BREAKFAST AND 10 UNITS
BEFORE SUPPER..."

Observations in Resident #46's room on 8/11/09
at 6:22 AM, revealed Nurse #14 administered
Novolin N 20 units in Resident #46's abdomen.
The door to Resident #46's room was left open,
the curtain was not pulled, and the resident's
abdomen was exposed from the upper chest to the
pelvic area.

F 309

483.25 QUALITY OF CARE

SS=D

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 medical record review, review of
scheduled meal times, observation and interview,
it was determined the facility failed to obtain a
physician's order for medications or ensure
accuchecks were obtained in accordance with
physician's orders for 7 of 46 (Residents #19, 24, 26, 29, 32, 34 and 35) sampled residents.

The findings included:

On 08-12-09, the Staff
Development Coordinator
reeducated all Licensed Nurses
regarding Professional
Standards of Care. Please see
attached in service education

On 08-06-09, the Staff
Development Nurse began an in-
depth in-service for all Licensed
Nurses regarding:

- Compliance with HIPPA
  regulations during
  medication pass

The facility Compliance Nurse,
Quality Improvement Nurse and
Staff Development Coordinator
will also perform monthly
medication pass reviews on
alternating shifts for 3 months
and then quarterly as part of an
ongoing Quality Improvement
Plan. The results of the
medication passes will be
reported to the Quality
Improvement Team for review.

The Facility Compliance Nurse
and designees will complete
Medication Pass audits monthly
with different staff on different
shifts. Privacy audit will be a
part of the medication pass
audit.
309 Continued From page 16

1. Medical record review for Resident #19 documented an admission date of 7/27/09 with diagnoses of Prostate Cancer, Depression, Gout, Osteoarthrosis, Seizure Disorder, Peripheral Vascular Disease, Hypertension, Coronary Artery Disease, and Diabetes Mellitus. Review of a hand-written, unsigned order for 7/27/09 through 7/31/09 documented "...Accuchecks AC [before meals] & [and] HS [hour of sleep] c [with] Novolog SSI [sliding scale insulin] ...Ibufrofen 600 mg [milligrams] po [by mouth] tid [three times a day] ...Finasteride 5 mg po Q [every] day... Aggrenox 25/250 mg po Q day... Monopril 10 mg give 2 tabs po Q day... Hydrochlorothiazide 25 mg po Q day... Cozaar 50 mg give 1/2 tab po Q day... Nifedipine 90 mg po Q day... Atenolol 25 mg po Q day... Allopurinol 300 mg po Q day... Vit [vitamin] C 500 mg po Q day... Vit B12 1000mg po q day... Vit E 400 units po q day... Casodex 50mg po bid... Gilmepril 2mg po bid [two times a day]... Lortab 7.5 mg po Qid [four times a day]... Potassium 20 meq [milliequivalents] po daily... Dilantin 100 mg give 4 caps [capsules] Q hs... Simvastatin 40 mg give 1/2 tab Q day... Remeron 7.5 mg po Q hs... Senokot 8.6-50mg q day pm [as needed]... Colace 100 mg give 2 po bid pm... Metformin 500mg po bid..." Review of the July and August 2009 Medication Administration Records (MAR) documented the medications as noted above had been administered to Resident #19. There was no documentation of a signed physician's order for the administration of these medications.

F 309
Continued From page 17
per Peg [Percutaneous Endoscopic Gastrostomy] daily, Celaex 20 mg 1 per Peg daily, Prevacid Solu [solution] TAB [tablet] 30 mg 1 per Peg daily, Keppra 750 mg/ [per] 7.5 ml [milliliters] per Peg BID, Glucophage 1000 mg 1 per Peg q [every] day, Phenytoin 100 mg/4ml susp [suspension] per Peg BID, Actos 45 mg 1 per Peg daily, Labetalol 200 mg 1 per Peg TID [three times a day], Altace 5 mg 1 per Peg daily, Omeprazole 20 mg 1 per Peg daily, Floxin OTC (ear gtt[s][drops]) 10 gtt[s] L [left] ear BID X [times] 7 days, Novolog Mix 70/30 15 units SQ [subcutaneous] BID, Albuterol 2.5 mg/0.5ml 1 per neb [nebulizer] TID (as needed), Atrovent 0.5 mg/2.5ml 1 per Neb TID (as needed)... Review of a hand-written, unsigned order for 6/15/09 documented, "Norvac 5 mg 1 per Peg, Celaex 20 mg 1 per Peg daily, Prevacid soluo [tablet] TAB 30 mg 1 per Peg daily, Keppra 750 mg/7.5 ml per Peg BID, Glucophage 1000 mg 1 per Peg q day, Phenytoin 100 mg/4ml susp per Peg BID, Labetalol 200 mg 1 per Peg TID, Altace 5 mg 1 per Peg daily, Hydrocodone 7.5/500 mg Lquid per Peg q 6 hours PRN [as needed], Bactroban 2% nasal ointment q 12 hours, Actos 30 mg per Peg daily, Novolin 70/30 15 units SQ at 8:00 AM and 8:00 PM, Floxin Otic drops-10 gtt[s] L ear x 7 days, Albuterol 25mg/0.5 ml 1 per Neb TID as needed, Atrovent 0.5mg/2.5ml 1 per Neb TID (as needed)... Review of a hand-written, unsigned order for 6/19/09 through 6/30/09 documented, "Ambien 10 mg at HS per Peg..." Review of the June 2009 MAR documented these medications as noted above had been administered to Resident #24. There was no documentation of a signed physician's order for the administration of these medications.

3. Medical record review for Resident #26 documented an admission date of 12/18/09 with

F 309
Resident # 19, 24, 26, 32, 34 and 35 medical record was reviewed by facility management nurses under the direction of the Director of Nurses. The records were reviewed to ensure orders had been signed and that "accu checks" were being performed as prescribed.

All Residents have the potential to be affected.

The Medical Records Clerk will audit at least 50% of all medical records monthly for 3 months to ensure that the attending Physician has signed the monthly recap orders by the 7th day of each month. The audit will begin on September 1st, 2009 when the new orders are printed. The facility will continue to keep the original signed telephone order on file for reference. The Medical Records Director will report the audit findings to the Quality Improvement Team for review.

8-15-09
8-24-09 and ongoing
### F 309

**Diagnosis:**
Diagnosis included Organic Brain Syndrome, Alzheimer's, Diabetes Mellitus, Osteoarthritis, Atrial Fibrillation, Peripheral Vascular Disease, and Left Below the Knee Amputation. Review of the May 2009 physician's orders documented an order for Accuchecks to be obtained AC and HS. Review of the May 2009 Accuecheck/Insulin Log revealed there was no documentation found the accuchek was performed on 5/30/09 and 5/31/09 at HS as ordered.

4. **Medical record review for Resident #29**
documented an admission date of 10/23/07 with diagnoses of Diabetes, Hypertension, Alzheimer's and Hypertrophy of Prostate. Review of the Physician's order dated 6/16/09 documented, "...ACCUCHECKS TWICE DAILY 6:30 AM 4:30 PM..." Review of the accuecheck insulin log for 6/30/09 revealed no documentation of the accuchek being done at 4:30 PM.

5. **Medical record review for Resident #32**
documented an admission date of 4/23/09 and a re-admission date of 5/15/09 with diagnoses of Congestive Heart Failure, Hypertension, Urinary Tract Infection, Chronic Obstructive Pulmonary Disease, Diabetes and Status Post Left Below the Knee Amputation. Review of the physician's order initiated 5/15/09 documented Accuchecks AC. Review of the June 2009 BS flow sheet revealed no documentation of an accuchek being obtained at 11:00 AM on 6/2/09, nor could the facility staff provide that documentation.

6. **Medical record review for Resident #34**
documented an admission date of 5/14/09 with diagnoses of Diabetes Mellitus type II, Hypertension, Seizures, Aortic Stenosis, Congestive Heart Failure, and Suspected

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**On 08-06-09, the Staff Development Nurse began an in-depth in-service for all Licensed Nurses regarding:**

**Diabetes and Insulin Administration:**
- General diabetes discussion that included type 1 and 2 diabetes
- Lab values for diabetes
- Bedside glucose monitoring
- Oral Hypoglycemics and their actions
- Injectable medications to treat Diabetes
- Types of Insulin/side effects and actions
- Signs and symptoms of Hyperglycemia
- Signs and symptoms of Hypoglycemia
- Required documentation
- Factors that may affect glucose levels
- Actual administration of insulin products
- Facility Insulin Protocol
- Physician Notification
Meningitis. Review of a physician’s order dated 6/4/09 documented, "Accuchek AC and HS." Review of Resident #34’s scheduled (east hall) meal times were for breakfast to be served at 7:50 AM and dinner to be served at 5:45 PM. Review of Resident #34’s June 2009 Accuchek/Insulin Log revealed accucheks were not obtained on 6/6/09 at 9:00 PM, 6/14/09 at 6:30 AM and 9:00 PM and on 6/22/09 at 6:30 AM.

Review of a physician’s order initiated on 7/8/09 documented, "Accuchek Twice Daily..." Review of the July 2009 Accuchek/Insulin Log revealed accucheks were to be obtained at 6:00 AM and 5:00 PM. Review of the July 2009 Accuchek/Insulin Log revealed accucheks were not obtained for 7/16/09 at 5:00 PM, 7/20/09 at 5:00 PM, 7/26/09 at 6:00 AM, and 7/27/09 at 6:00 AM.

7. Medical record review for Resident #35 documented an admission date of 12/29/08 with diagnoses of Diabetes, Seizure, Hypertension, Paranoid Schizophrenia, Depression, Glaucoma and Anxiety. Review of a physician’s order initiated 4/1/09 documented to do accucheks AC and HS. Review of Resident #35’s meal times (west hall) were for breakfast to be served at 7:40 AM, lunch at 11:30 AM and dinner at 6:30 PM. Review of Resident #35’s May 2009 Accuchek/Insulin Log revealed accucheks were to be obtained at 6:30 AM. There was no documentation an accuchek was obtained on 5/30/09 at 6:30 AM. Review of Resident #35’s June 2009 Accuchek/Insulin Log revealed accucheks were to be obtained at 11:00 and 4:30 PM. There was no documentation an accuchek was obtained on 6/26/09 at 11:00 AM and 6/30/09 at 4:30 PM.
### F 309
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Continued From page 20
Review of Resident #35's 7/1 through 7/14/09
Accuchek/Insulin Log revealed the HS
accucheks were to be obtained at 9:00 PM.
There was no documentation an accuchek was
obtained on 7/7/09 9:00 PM. The 7/15/09 through
7/31/09 Accuchek/Insulin Log revealed
accucheks were to be obtained at 8:00 AM.
There was no documentation an accuchek was
obtained on 7/29/09 at 8:00 AM.
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### F 315
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483.25(d) URINARY INCONTINENCE
SS=D
Based on the resident's comprehensive
assessment, the facility must ensure that a
resident who enters the facility without an
indwelling catheter is not catheterized unless the
resident's clinical condition demonstrates that
catheterization was necessary; and a resident
who is incontinent of bladder receives appropriate
treatment and services to prevent urinary tract
infections and to restore as much normal bladder
function as possible.

This REQUIREMENT is not met as evidenced by:
Based on review of "Sorensen and Luckmann's
Basic Nursing A Psychophysioligic Approach" and
observation, it was determined the facility
failed to assure the catheter tubing was not
touching the floor for 1 of 3 (Residents #2)
sampled residents with catheters.

The findings included:
Review of "Sorensen and Luckmann's Basic
Nursing A Psychophysioligic Approach Third
Edition" page 1187 documented, "...The bag and
tubing must never touch the floor."
```
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(F1) PROVIDER/SUPPLIER/CNA IDENTIFICATION NUMBER:
445356

(F2) MULTIPLE CONSTRUCTION
A. BUILDING ____________________
B. WING ____________________

(F3) DATE SURVEY COMPLETED
08/12/2009

NAME OF PROVIDER OR SUPPLIER
TENNESSEE STATE VETERANS HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
2885 MAIN STREET
HUMBOLDT, TN 38343

(F4) 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)

(F5) COMPLETION DATE

F 315 Continued From page 21
Observations in Resident #2’s room on 8/3/09 at 2:50 PM and on 8/4/09 at 9:00 AM, revealed Resident #2’s Foley catheter tubing was touching the floor.

F 322
483.25(g)(2) NASO-GASTRIC TUBES

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review and observation, it was determined the facility staff failed to check placement of the Percutaneous Endoscopic Gastrostomy (PEG) tube prior to administration of medications for 1 of 2 (Resident #2) sampled residents with PEG tube observed during medication administration.

The findings included:
Review of the facility’s "Medication Administration-Enteral Tubes" policy documented, "...Verify tube placement. Unclamp tube and use the following procedures: Insert a small amount of air into the tube with the syringe and listen to stomach with stethoscope for gurgling sounds. Aspirate stomach contents with syringe. Check residual. Allow stomach contents to go back into stomach...Allow medication to flow down tube via gravity..."

F 315 Resident #2 had the Foley tubing off of the floor on observation. All Residents with Foley catheters have the potential to be affected.

8-24-09

F 322 The Staff Development Nurse educated the staff nurses regarding Infection Control and Foley Catheter Care.

8-24-09 and on-going

The Director of Nurses or designee will make random rounds to observe for compliance with the professional standard of Foley tubing being off of the ground. The Audits will be conducted weekly for 3 weeks and will be reported to the Quality Improvement Team for review.

Infection Control education is offered during orientation and yearly through the TSVH University. The Staff Development Coordinator will be responsible for tracking the education hours.
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| F 322   |        |     | Continued From page 22

Observations in Resident #2's room on 8/4/09 at 4:05 PM, revealed Nurse #3 administered Vitamin C 500 milligrams to Resident #2 via PEG tube. Nurse #3 did not check the placement of the PEG tube prior to administration of the medication.

F 332 SS=K
MEDICATION ERRORS

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, review of "2005 American Society of Consult Pharmacists and Med-Pass", review of the facility's dining times, medical record review, observation and interview, it was determined the facility failed to ensure the medication error rate was less than five percent (%) for Residents #11, 12, 17, 18, 19, 46 and Random Resident (RR #2). Four (4) of 8 (Residents #12, 17, 18 and 19) residents observed receiving insulin had medication errors with insulin administration. Six (6) of 13 nurses (Nurses #2, 3, 5, 6, 9 and 10) made 10 errors out of 49 opportunities for error which resulted in a medication error rate of 20%. The failure to administer insulin as ordered by the physician and the failure to administer insulin within 30 minutes.

Tennessee State Veterans Home neither believes nor admits that any deficiencies existed before, during or after the survey reflected herein. Tennessee State Veterans Home reserves all rights to contest the survey findings through Informal Dispute Resolution or formal appeal proceedings. This plan of correction is not intended to establish any standard of care, contract obligation or position. Nothing in this plan of correction should be construed as admission of guilt or considered a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which Tennessee State Veterans Home does not waive and reserves the right to assert in any civil, administrative or criminal claim, action or proceeding Tennessee State Veterans Home its response, credible allegations of compliance and plan of correction as part of its on-going efforts to provide quality of care to its Residents.
Continued from page 23 of meals placed diabetic residents in immediate jeopardy. The immediate jeopardy began 7/29/09. The facility remained out of compliance at a scope and severity level "E" (a pattern deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure that the policies and procedures and training implemented by the facility could be reviewed by the Quality Assurance (QA) Committee.

The findings included:

1. Medical record review for Resident #12 documented an admission date of 3/16/09 with diagnoses of Diabetes Type II, Pressure Ulcer of the Heel, Organic Brain Syndrome, and Epilepsy. Review of the physician's orders dated 7/5/09 documented "Novolin R 100 UNITS/ML AS DIRECTED ACCORDING TO THE SLIDING SCALE...251- [to] 300 = [amount of insulin to be administered] 6 UNITS..." The current orders dated 7/5/09 did not include an order for Megace 4 mg to be administered.

Observations in Resident #12's room on 8/3/09 at 4:03 PM, revealed Nurse #3 administered Novolin R 6 units (U) subcutaneous (SQ) in the right abdomen.

Observations of the evening meal on the West Hall on 8/3/09 revealed the meal tray was not served to Resident #12 until 5:17 PM. Resident #12 did not take the first bite of the meal until 5:22 PM, 1 hour and 18 minutes after administration of the insulin. The administration of the insulin more than 30 minutes before the meal resulted in medication error #1.

Resident 11, 12, 17, 18, 19, 46, RR2, were reviewed by facility Management Nurses for order clarity. The attending Physicians were notified if any medication errors were identified.

All Residents receiving medications have the potential to be affected. This includes medications by all routes of administration.

On 08-05-09 the Staff Development Coordinator, who is a Masters prepared Registered Nurse, conducted an in service with all Licensed Nurses regarding Insulin Administration, the facility policy and procedure for blood glucose checks, insulin protocol and Physician Notification of Blood Glucoses below 60 or above 400.
## F 332

Observations in Resident #12's room on 8/4/09 at 4:15 PM, revealed Nurse #2 administered Megace 4 mg by mouth to Resident #12. This resulted in medication error #2.

During an interview in the conference room on 8/5/09 at 2:40 PM, the Director of Nursing (DON) stated, "I don't see an order for the Megace." At that time the Corporate Compliance Nurse stated, "I don't see it [order for Megace] either."

2. Medical record review for Resident #17 documented an admission date of 4/21/08 with the diagnoses of Intracranial Abscess, Alcoholic Dementia, Chronic Airway Obstruction and Seizures. Review of physician's orders dated 2/5/09 documented, "NOVOLIN R 100 UNITS/ML 10 UNITS SQ THREE TIMES 30 MIN [MINUTES] BEFORE MEALS."

Observations in Resident #17's room on 8/3/09 at 4:35 PM, revealed Nurse #10 administered Novolin R 10 U SQ in Resident #17's abdomen.

Observations in the main dining room on 8/3/09 revealed the meal tray was not delivered to Resident #17 until 5:35 PM. The delivery of Resident #17's meal tray one hour after the administration of Novolin R 10 U SQ resulted in medication error #3.

3. Medical record review for Resident #18 documented an admission date of 7/18/07 with diagnoses of Organic Brain Syndrome, Diabetes, Hypertension and Hyperlipidemia. Review of the physician's orders dated 7/5/09 documented, "NOVOLIN R 100 UNITS/ML AS DIRECTED ACCORDING TO SLIDING SCALE. SLIDING SCALE (REGULAR) 60-100= ORANGE JUICE OPEN BOTTLE 20 UNITS SQ THREE TIMES 30 MIN [MINUTES] BEFORE MEALS."
**TENNESSEE STATE VETERANS HOME**

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<td>Continued From page 25</td>
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- Compliance with timing of medication administration
- "DO NOT CRUSH" medications
- Medications that require vital signs
- Liquid medications
- Topical/external medications
- Metered dose inhalers
- Ear drops
- Rectal Medications
- Giving medications safely
- Insulin (discussed in depth during Diabetes in service)

Diabetes and Insulin Administration:
- General diabetes discussion that included type 1 and 2 diabetes
- Lab values for diabetes
- Bedside glucose monitoring
- Oral Hypoglycemics and their actions
- Injectable medications to treat Diabetes
- Types of Insulin/side effects and actions
**F 332** Continued From page 26

Seizure Disorder, Coronary Artery Disease, Gout, Rheumatoid Arthritis, and Peripheral Vascular Disease. Review of an unsigned physician's order dated 7/28/09 by the nurse documented an order for "Accuchecks [before meals] & [and] HS [hour of sleep] c [with] Novolog SS1 [sliding scale insulin]. SLIDING SCALE (REGULAR) ...201-250=4 units..."

Observations in Resident #19's room on 8/3/09 at 4:12 PM, revealed Nurse #3 administered Novolog 4 U SQ in Resident #19's right abdomen.

Observations of the evening meal on the West Hall on 8/3/09 revealed the meal tray was not served to Resident #19 until 5:42 PM, 1 hour and 30 minutes after administration of the insulin. The administration of the insulin more than 30 minutes before the meal resulted in medication error #5.

5. Review of the facility's medication administration policy documented, "7.1 GENERAL GUIDELINES... PROCEDURES Medication Administration...7. When administering potent medications in liquid form or those requiring precise measurement, such as digoxin, devices provided by the manufacturer or obtained from a supplier, (e.g. [for example] oral syringes) are used to allow accurate measurement of doses."

Medical record review for Resident #11 documented an admission date of 1/1/09 with diagnoses of End Stage Alzheimers, Diabetes Mellitus Type II, Cancer of the Prostate, Depression, and Anxiety. Review of the physician's orders dated 7/25/09 documented an order for "FERROUS SULF [Sulfate] 220 MG"
F 332 Continued from page 27

[milligrams] / [per] 5 M [milliliter] 325 MG...THERA TAB 1 TABLET PER TUBE EVERY DAY..."

Observations of medication administration in Resident #11's room on 8/4/09 at 9:20 AM, revealed Nurse #1 poured 7.5 cubic centimeter (cc) (330 mg) of Ferrous Sulfate in a graduated medicine cup and crushed a Multivitamin plus (+) Iron tablet and administered both medications by Percutaneous Endoscopic Gastrostomy tube. The administration of Ferrous Sulfate 330 mg (7.5 cc) instead of the 325 mg (7.38 cc) as ordered by the physician resulted in medication error #6. The administration of the Multivitamin + Iron instead of the Thera Tab as ordered resulted in medication error #7.

During interview in the hallway outside room E29 on 8/4/09 at 3:35 PM, Nurse #5 stated "I gave the Multivitamin with iron. That's what we give when Thera Tab is ordered."

During an interview in the East nurses' station on 8/4/09 at 3:45 PM, the Pharmacy Consultant stated, "going to ask the doctor to write the order for 7.5 cc. It would be 7.386 cc. We need to take the 325 mg off and it say 7.5 cc. Will make sure that order gets clarified."


On 08-10-09 the facility Management Nurses began observing Licensed Nurses perform blood glucose checks and administer Insulin. The observation is being documented on the Insulin QA form. (See attached examples) Each Nurse will be checked off twice before being allowed to give Insulin without an observer present. Going forward, all new hires must receive observation when giving Insulin or performing blood glucose checks and will continue to be observed until there are two correct observations.

On 08-12-09, the Staff Development Coordinator reeducated all Licensed Nurses regarding Professional Standards of Care. Please see attached in service education.
The Pharmacy Consultant will continue to perform monthly medication pass observations with special emphasis on Insulin Administration. The monthly medication passes with the Pharmacy Consultant will continue for 6 months or as needed.

The facility Compliance Nurse, Quality Improvement Nurse and Staff Development Coordinator will also perform monthly medication pass reviews on alternating shifts for 3 months and then quarterly as part of an on-going Quality Improvement Plan. The results of the medication passes will be reported to the Quality Improvement Team for review.
Continued from page 29
immediate jeopardy.

The immediate jeopardy existed from 7/29/09 to 8/12/09.

On 8/12/09 the facility presented the survey team an acceptable allegation of compliance as follows:

a. On 8/5/09 the Staff Development Coordinator, conducted an in-service with all Licensed Nurses regarding insulin administration, facility policy and procedure for blood glucose checks, insulin protocol and physician notification of blood glucose values below 60 and above 400. On 8/5/09 the facility Medical Director and two attending physicians re-approved the facility insulin protocol.

b. On 8/6/09 the attending physicians were notified of errors by the Management Nurses. On 8/6/09, the Staff Development Nurse began an in-depth in-service for all Licensed Nurses regarding Medication Administration and Diabetes and Insulin Administration. A re-education will take place within 3 months conducted by the Tennessee State Veterans Home University training system. Educational content was approved by the Medical Director. On 8/6/09 the facility Management Nurses began the process of clarifying/verifying all insulin orders for accuracy. 100 percent (%) of all residents had received clarification/verification by 8/7/09.

c. On 8/10/09 the facility Management Nurses began observing Licensed Nurses perform blood glucose checks and insulin administration.

d. On 8/11/09 a skills fair was conducted by the Staff Development Masters prepared Registered Nurse and sister facility Certified Diabetic Educator. The content included insulin administration with return demonstration,
**TENNESSEE STATE VETERANS HOME**

**2865 MAIN STREET**
**HUMBOLDT, TN 38343**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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| **SUMMARY STATEMENT OF DEFICIENCIES** | Continued From page 30
| **(Each deficiency must be preceded by full regulatory or LSC identifying information)** | physician notification, professional standards and facility policy for insulin administration and blood glucose checks with return demonstration.
| | e. On 8/12/09, the Staff Development Coordinator re-educated all Licensed Nurses regarding professional standards of care.
| | f. The Admissions Coordinator will alert the Director of Nurses of all new Diabetic admissions, regardless of type of Diabetes. A log will be kept of notification. The Director of Nurses or designee will audit all new admissions for order transcription accuracy, blood glucose checks/insulin log accuracy and physician notification when blood glucose is outside the prescribed parameters. Newly admitted Diabetics will be audited at 100 percent (%) for 3 months. The Director of Nurses or designee will report finding to Quality Improvement Committee for review. The committee will reserve the right to extend the auditing time frame.
| | g. The Director of Nurses or designee(s) will audit 100% of all Diabetic medical records for accuracy and physician notification weekly times 4 then monthly for 3 months and report finding to Quality Improvement Team for review. The Regional Nurses will review at least 15 Diabetic medical records monthly and findings will be reported to the facility Administrator, Director of Nurses and Executive Director.
| | h. Resident #20 was examined by the facility Medical Director and attending physician on 8/12/09. A plan of care was updated and agreed upon by facility Medical Director and attending physician.
| | i. The Pharmacy Consultant will continue to perform monthly medication pass observations with emphasis on Insulin Administration. This will continue for 6 months or as needed.
| | j. The facility Compliance Nurse, Quality

**PREVIOUS VERSIONS OBSOLETE**

**Event ID: QTSX11**
**Facility ID: TN2700**
**If continuation sheet Page 31 of 77**
Continued From page 31
Improvement Nurse and Staff Development Coordinator will perform monthly medication pass reviews on alternating shifts for 3 months and then quarterly as part of an on-going Quality Improvement Plan. The results of the medication passes will be reported to the Quality Improvement Team for review.

After receiving the facility's acceptable allegation of compliance the surveyors verified that the corrective actions had been put in place to abate the immediate jeopardy. The surveyors verified the corrective actions by conducting an additional medication administration pass for observations of correct insulin administration and timely meal service, observed facility administrative staff monitoring nurses administering medications, reviewed in-service records and interviewed staff to verify the staffs knowledge of information received during the in-services. The immediate jeopardy was abated as of 8/12/09. The facility remains out of compliance at a scope and severity of "E".

483.25(m)(2) MEDICATION ERRORS

The facility must ensure that residents are free of any significant medication errors.

This REQUIREMENT is not met as evidenced by:
Based on policy reviews, review of in-service records, review of meal times, review of the "MED-PASS" provided by the American Society of Consultant Pharmacists, medical record review, observations and interviews, it was determined the facility failed to ensure that residents were free of significant medication errors. The nursing staff failed to obtain blood
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**F 333** Continued From page 32  

Sugars (BS) as ordered, failed to administer correct dosages of sliding scale insulin (SSI) as ordered, failed to administer insulin within 30 minutes of meals and/or failed to obtain signed orders for insulin administration for 20 of 30 (Residents #4, 10, 11, 17, 18, 19, 20, 24, 26, 29, 32, 34, 35, 36, 37, 38, 40, 42, 43 and 45) sampled diabetic residents. The failure to administer insulin as ordered, obtain BS as ordered and/or notify the physician of BS below 60 and/or above 401, placed all residents receiving insulin in immediate jeopardy. The immediate jeopardy began 7/29/09. The facility remained out of compliance at a scope and severity level "E" (a pattern deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure that the policies and procedures and training implemented by the facility could be reviewed by the Quality Assurance (QA) Committee.

The findings included:

1. Review of the facility's "Medication Administration General Guidelines" policy documented "...b. Medications to be given with meals are to be scheduled for administration at the resident's meal times..."

Review of the facility's "Blood Sugar/Sliding Scale Monitoring" policy provided by the facility to be used as the standing order for sliding scale insulins documented, "...1.) A written physician order for sliding scale insulin is required for all diabetic residents. The standard sliding scale that is utilized at [named facility] is as follows: If blood sugar [BS] is less than [<=] 60...Call MD [Medical Doctor] hold any scheduled insulin until verified.

**TENNESSEE STATE VETERANS HOME**

**STREET ADDRESS, CITY, STATE, ZIP CODE**  
2865 MAIN STREET  
HUMBOLDT, TN 38343

**DATE SURVEY COMPLETED**  
09/12/2009

**PROVIDER'S PLAN OF CORRECTION**

Tennessee State Veterans Home neither believes nor admits that any deficiencies existed before, during or after the survey reflected herein. Tennessee State Veterans Home reserves all rights to contest the survey findings through Informal Dispute Resolution or formal appeal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position. Nothing in this plan of correction should be construed as admission of guilt or considered waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which Tennessee State Veterans Home does not waive and reserves the right to assert in any civil, administrative or criminal claim, action or proceeding Tennessee State Veterans Home its response, credible allegations of compliance and plan of correction as part of its on-going efforts to provide quality of care to its Residents.
F 333 Continued From page 33

with MD... If BS 150- [to] 200... Give 2 units of Regular insulin... If BS 201-250... Give 4 units of Regular Insulin... If BS 251-300... Give 6 units of Regular Insulin... If BS 301-350... Give 8 units of Regular Insulin... If BS 351-400... Give 10 units of Regular Insulin... If BS is greater than 401... Give 12 units of Regular Insulin. Recheck in 2 hrs [hours], if still > [greater than] 401 call MD... 2.) Physician orders for custom sliding scale intervention may be written specifically for individual residents by the Physician and will supercede the facility approved sliding scale... 3.) Signs and symptoms of hypoglycemia: a.) Early symptoms: Sweating... Tremor... Pallor... Tachycardia... Palpitations... Nervousness... 4.) Treat hypoglycemia promptly with: a.) 4 oz. [ounces] juice, b.) 1 cup skim milk, c.) 4 packets sugar, or d.) Glucagon 1 mg [milligram] (subcutaneously [SQ] or I.M. [intramuscular]) is given if the resident cannot ingest a sugar treatment..."

During an interview in the conference room on 8/5/09 at 2:30 PM, the Director of Nurses and the Regional Compliance Nurse was asked what the staff is supposed to use for sliding scale insulin. The Compliance Nurse stated, "...They [nurses] should go with what the order says, unless there's a clarification order to convert to the protocol, they should use the doctor's order... should have a standing order signed by [named medical director]... should be signed by all the doctors..."

During an interview in the conference room on 8/5/09 at 4:00 PM, the Compliance Nurse was asked how the staff knows which regular insulin to use. The Compliance Nurse stated, "...I see what you mean... I'll rewrite the policy... I'll call [named medical director] and ask her..."

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<thead>
<tr>
<th>F 333</th>
<th>1. Resident #</th>
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<tbody>
<tr>
<td>4,10,11,17,18,19,20,24,26,29,32,3</td>
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<td>4,35,36,37,38,40,42,43,46 and 46</td>
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1. Resident #
   4,10,11,17,18,19,20,24,26,29,32,3
   4,35,36,37,38,40,42,43 and 46
   Insulin and finger stick documentation records and Physician Orders for Insulin and finger stick blood sugar checks were reviewed by the facility Management Nurses under the direction of the Director of Nurses for accuracy of the order and also for accuracy of the documentation. If a Resident had an order discrepancy, the management nurse notified the Physician for clarification.

2. On 08-06-09 the facility

Management Nurses began the process of clarifying/verifying all Insulin orders for accuracy. 100% of all Residents had received clarification/verification by 08-07-09.
2. During an interview in the conference room on 8/11/09 at 9:45 AM, the Regional Compliance Nurse stated that the Quality Assessment (QA) process started in March 2009 concerning problems with compliance with diabetic residents. The Regional Compliance Nurse stated, "...That's when they [facility] started terminating people [failing to perform acuchecks as prescribed, notifying physician of low and high blood sugars and administering insulin as ordered]...did group education...maybe we should do one-on-one..."

As a result of the QA findings in March 2009 the facility did a nursing Inservice on 3/29/09 as follows: "...Topics...4. Accucheck & [and] Insulin Policy and Procedure...6. Physician and Family Notification...Accucheck and Insulin Policy and Procedure...1. Accuchecks are to be performed as prescribed. The Accucheck will be documented on the Accucheck and Insulin flow sheet...If the Accucheck is below 80 or above 401 or as stated by the Physician, YOU MUST NOTIFY THE ATTENDING PHYSICIAN AND DOCUMENT. Document that the MD was notified and what the results of the notification are. FAILURE TO DO THIS WILL RESULT IN DISCIPLINARY ACTION LEADING VERY QUICKLY TO TERMINATION...2. Scheduled Insulin will be given as directed. If there is a reason to hold the insulin, YOU WILL NOTIFY THE ATTENDING PHYSICIAN AND DOCUMENT THE NOTIFICATION AND THE RESULTS OF THE NOTIFICATION. THERE IS NO EXCEPTION TO THIS RULE. 3. Sliding Scale Insulin will be administered as prescribed. IF THE ACCUCHECK IS TOO HIGH FOR THE PRESCRIBED DOSE, THEN YOU WILL NOTIFY THE ATTENDING PHYSICIAN AS PER POLICY.

3. On 08-10-09 the facility Management Nurses began observing Licensed Nurses perform blood glucose checks and administer Insulin. The observation is being documented on the Insulin QA form. (See attached examples) Each Nurse will be checked off twice before being allowed to give Insulin without an observer present. Going forward, all new hires must receive observation when giving Insulin or performing blood glucose checks and will continue to be observed until there are two correct observations.

4. There was a skills fair conducted by the facility Staff Development Masters prepared Registered Nurse and sister facility Certified Diabetic Educator on 08-11-09 for all Licensed Nurses with content that included Insulin Administration with return demonstration, Physician Notification, Professional Standards and facility policy for Insulin Administration and Blood Glucose Checks with return demonstration. Please see attached copy.

8-10-09 and on-going
F 333 Continued From page 35

AGAIN, THERE IS NO EXCEPTION TO THIS RULE... Physician and Family Notification: 1. Licensed Nurses will notify Physician's and families/responsible parties of change in Resident condition. This is a federal requirement and not up for discussion. Not only is it a federal requirement, it is required of you by the Nurse Practice Act that you document the notification... Accountability: All Licensed Nurses will be held accountable for their actions or inactions... bad care is stopping, apathy is stopping...

Review of the June 2009 Consultant Pharmacist's Monthly Report documented "...Inservice on medication pass...insulin...Things to address: Sliding scale insulin scheduled before meals should not be given more than thirty minutes before a meal. Please make sure times of administration on MARs [Medication Administration Record] are consistent with meal times..." A memorandum attached to the report to "Nursing Staff" dated 6/3/09 documented, "...Subject: Time of Insulin Administration... Please make sure that the sliding scale regular insulin ordered before meals is not given more than thirty minutes before scheduled meal times. On the June MARs there are several insulin doses charted as given at 4PM which would be more than thirty minutes before the evening meal trays come out. Please wait to give the insulin until meal trays will be out within thirty minutes. If a meal tray is late then you must give a snack to a resident who has already received insulin. This also applies to all insulin mixtures that contain regular insulin (e.g. [for example] Humulin 70/30 and Novolin 70/30)."

Review of the facility's "INSULIN" pharmacy inservice dated 6/8/09 documented "...Rapid

5. On 08-05-09 the Staff Development Coordinator, who is a Masters prepared Registered Nurse, conducted an in service with all Licensed Nurses regarding Insulin Administration, the facility policy and procedure for blood glucose checks, insulin protocol and Physician Notification of Blood Glucoses below 60 or above 400.

6. On 08-06-09, the Staff Development Nurse began an in-depth in-service for all Licensed Nurses regarding:

Medication Administration:
- 5 Rights of medication administration
- Oral medications
- Subcutaneous injections
- Intramuscular injections
- National Patient Safety Goals for medication administration
- Definition of medication error
- Obtaining and following Physician orders
- Drug manufacturers specifications
- Accepted professional standards and principles
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| F 333         | Continued From page 36 acting insulins - Novolog, Humalog, Apidra - need to be given 5- to 15 minutes prior to food... ALWAYS specify the insulin to be used on the sliding scale when you write the order... "Review of the facility's "INSULIN ADMINISTRATION TIMES" documented "...Rapid-acting: Novolog, Humalog, Apidra Resident must have meal tray or snack within 10-15 minutes, or physician can order after meal administration... Short-acting: Regular (Novolin, Humulin) Resident must have a meal tray or snack within 30 minutes...

During an interview with the Consultant Pharmacist on 8/12/09 at 8:35 AM, the Consultant Pharmacist stated that had identified a problem with insulins around the first of June 2009. The Consultant Pharmacist stated that during the inservice she did in June 2009, she had told the facility staff that "...the insulin times should be changed according to meals [times]...Told them AC [before meals] should be scheduled at meal times...can't give [insulin] one hour before the meals... go by the normal med times..." Insulin dosage times were not changed per the pharmacy recommendation/ inservice to correspond to the individual resident's meal times until after the Survey team identified the problem and notified the facility on 8/5/09.

Review of a July 2009 inservice provided by the facility on "Documentation" documented "...Accuchecks and Glucose Documentation: All Licensed Nurses will utilize the orange Glucose monitoring form. The Licensed Nurse will observe the stated ranges and notify the attending Physician when the glucose is outside the prescribed range. There is no exception to this and any offender will be reprimanded, leading to termination for repeat offenders. The Licensed

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</table>
| F 333         | • Definition of Significant Medication Error
|               | • Resident Condition
|               | • Drug category
|               | • Frequency of Errors
|               | • Compliance with HIPPA regulations during medication pass
|               | • Handwashing/infection control
|               | • Compliance with timing of medication administration
|               | • "DO NOT CRUSH" medications
|               | • Medications that require vital signs
|               | • Liquid medications
|               | • Topical/external medications
|               | • Metered dose inhalers
|               | • Ear drops
|               | • Rectal Medications
|               | • Giving medications safely
|               | • Insulin (discussed in depth during Diabetes in service)
Diabetes and Insulin Administration:

- General diabetes discussion that included type 1 and 2 diabetes
- Lab values for diabetes
- Bedside glucose monitoring
- Oral Hypoglycemics and their actions
- Injectable medications to treat Diabetes
- Types of Insulin/side effects and actions
- Signs and symptoms of Hyperglycemia
- Signs and symptoms of Hypoglycemia
- Required documentation
- Factors that may affect glucose levels
- Actual administration of insulin products
- Facility Insulin Protocol
- Physician Notification

A re-education will take place within 3 months via the TSVH University training system. Please see attached copy. The facility Medical Director reviewed the content of the education provided for content and approval was given.
F 333 Continued From page 38
UNITS...351 - 400 = 10 UNITS...>400 = 12 UNITS...

Review of Resident #20's BS flow sheet for May 2009 documented 124 opportunities for BS to be checked. The top of the May 2009 flow sheet for SSI documented "...Call MD if BS < 60 or > 400 Chart on Back..." There were 37 opportunities that there was no documentation that a BS was obtained. There were 12 with the wrong doses of insulin given. The BS with the incorrect SSI were as follows:

a. 5/8/09 at 11:00 AM - BS was (=) 231, Insulin given = 0, correct dose = 4 units (U).
b. 5/8/09 at 4:30 PM - BS = 323, Insulin given = 4, correct dose = 8 U.
c. 5/12/09 at 6:00 AM - BS = 160, Insulin given = 0, correct dose = 2 U.
d. 5/12/09 at 11:00 AM - BS = 294, Insulin given = 0, correct dose = 6 U.
e. 5/13/09 at 6:30 AM - BS = 155, Insulin given = 0, correct dose = 2 U.
f. 5/13/09 at 11:00 AM - BS = 310, Insulin given = 0, correct dose = 8 U.
g. 5/14/09 at 6:30 AM - BS = 159, Insulin given = 0, correct dose = 2 U.
h. 5/14/09 at 11:00 AM - BS = 255, Insulin given = 0, correct dose = 6 U.
i. 5/18/09 at 11:00 AM - BS = 193, Insulin given = 0, correct dose = 2 U.
j. 5/19/09 at 11:00 AM - BS = 394, Insulin given = 0, correct dose = 10 U.
k. 5/20/09 at 8:30 AM - BS = 224, Insulin given = 0, correct dose = 4 U.
l. 5/29/09 at 4:00 PM - BS = 366, Insulin given = 8, correct dose = 10 U.

The administration of the wrong doses of insulin resulted in significant medication errors.

7. On 08-05-09 the facility Medical Director and two attending Physicians re-approved the facility Insulin protocol. The protocol will be used unless otherwise prescribed.

8. On 08-12-09, the Staff Development Coordinator reeducated all Licensed Nurses regarding Professional Standards of Care.

9. "Diabetes Philosophy and Treatment Goals", a mandatory educational offering will be conducted on 08-14-09 by an additional Certified Diabetic Educator.

10. All Insulin Dependant Diabetics have the potential to be affected. The Admissions Coordinator will alert the Director of Nurses of all new Diabetic admissions, regardless of type of Diabetes. The Admissions Coordinator will keep a log of this notification. The Director of Nurses or designee will audit all newly admitted diabetics for the following:

- Order transcription accuracy
- Blood glucose checks/Insulin log accuracy
- Physician notification when blood glucose is outside the prescribed parameters
F 333 Continued From page 39
The top of Resident #20's May 2009 flow sheet for SSI documented "...Call MD if BS < 60 or > 400 Chart on Back [facility protocol]." There were 5 documented BS that were below 60 as follows:
- a. 5/5/09 at 6:30 AM - BS = 54.
- b. 5/8/09 at 6:30 AM - BS = 42.
- c. 5/11/09 at 6:30 AM - BS = 37.
- d. 5/19/09 at 6:30 AM - BS = 40.
- e. 5/22/09 at 6:30 AM - BS = 50.
There was no documentation of interventions put in place for low BS, there was no documentation of any follow-up on the low BS and there was no documentation the physician was notified of these low blood sugars.

There were 6 documented BS that were above 400 with no documentation that the BS was rechecked, and no documentation that the physician was notified. The BS were as follows:
- a. 5/8/09 at 8:00 PM - BS = 413.
- b. 5/11/09 at 4:00 PM - BS = 430.
- c. 5/13/09 at 8:00 PM - BS = 404.
- e. 5/14/09 at 8:00 PM - BS = 434.
- f. 5/20/09 at 4:00 PM - BS = 460.
- g. 5/28/09 at 4:00 PM - BS = 405.

Review of Resident #20's BS flow sheet for June 2009 documented 120 opportunities for BS to be checked. There were 10 opportunities that there was no documentation that a BS was obtained. There were 16 with the wrong doses of insulin given. The BS with the incorrect SSI were as follows:
- a. 6/5/09 at 9:00 PM - BS = 123, Insulin given = 2, correct dose = 0 U.
- b. 6/8/09 at 6:30 AM - BS = 188, Insulin given = 0, correct dose = 2 U.
- c. 6/12/09 at 11:00 AM - BS = 144, Insulin given =
F 333  Continued From page 40

2, correct dose = 0 U.

d. 6/15/09 at 6:30 AM - BS = 247, Insulin given = 0, correct dose = 4 U.
e. 6/15/09 at 12:00 Noon - BS = 379, Insulin given = 8, correct dose = 10 U.
f. 6/15/09 at 5:00 PM - BS = 350, Insulin given 10, correct dose 8 U.
g. 6/16/09 at 6:30 AM - BS = 339, Insulin given 0, correct dose 10 U.
h. 6/17/09 at 6:30 AM - BS = 184, Insulin given 0, correct dose 2 U.
i. 6/18/09 at 6:30 AM - BS = 297, Insulin given 0, correct dose 6 U.
j. 6/19/09 at 6:30 AM - BS = 184, Insulin given 0, correct dose 2 U.
k. 6/20/09 at 6:30 AM - BS = 255, Insulin given 0, correct dose 6 U.
l. 6/23/09 at 6:30 AM - BS = 333, Insulin given 0, correct dose 8 U.
m. 6/24/09 at 6:30 AM - BS = 315, Insulin given 0, correct dose 8 U.
n. 6/25/09 at 6:30 AM - BS = 207, Insulin given 0, correct dose 4 U.
o. 6/26/09 at 10:00 PM - BS = 291, Insulin given 4, correct dose 6 U.
p. 6/27/09 at 6:30 AM - BS = 233, Insulin given 0, correct dose 4 U.
The administration of the wrong doses of insulin resulted in significant medication errors.

The top of Resident #20's June 2009 flow sheet for SSI documented "...Call MD if BS < 60 or > 400 Chart on Back [facility protocol]..." There were 3 documented BS that were below 60 with no documentation of interventions taken to bring the BS up, and no documentation that the physician was notified. The 3 BS were as follows:
a. 6/5/09 at 6:30 AM - BS = 50.
b. 6/6/09 at 11:00 AM - BS = 56.

11. The Pharmacy Consultant will continue to perform monthly medication pass observations with special emphasis on Insulin Administration. The monthly medication passes with the Pharmacy Consultant will continue for 6 months or as needed.

12. The facility Compliance Nurse, Quality Improvement Nurse and Staff Development Coordinator will also perform monthly medication pass reviews on alternating shifts for 3 months and then quarterly as part of an on-going Quality Improvement Plan. The results of the medication passes will be reported to the Quality Improvement Team for review.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<thead>
<tr>
<th>ID</th>
<th>PREMISE</th>
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<td>c.</td>
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<td>There were 9 documented BS that were above 400 with no documentation that the BS was rechecked, and no documentation that the physician was notified. The BS were as follows:</td>
</tr>
<tr>
<td>a.</td>
<td>6/4/09 at 9:00 PM - BS = 410.</td>
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<td>b.</td>
<td>6/10/09 at 5:00 PM - BS = 495.</td>
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<td>c.</td>
<td>6/11/09 at 9:00 PM - BS = 441.</td>
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<td>d.</td>
<td>6/14/09 at 5:00 PM - BS = 469, no BS obtained at 9:00 PM.</td>
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<td>e.</td>
<td>6/16/09 at 5:00 PM - BS = 407.</td>
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<td>f.</td>
<td>6/18/09 at 9:00 PM - BS = 434.</td>
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<td>g.</td>
<td>6/18/09 at 6:00 PM - BS = 405.</td>
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<td>h.</td>
<td>6/22/09 at 5:00 PM - BS = 500, no BS obtained at 9:00 PM.</td>
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<tr>
<td>i.</td>
<td>6/30/09 at 5:00 PM - BS = 422.</td>
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Review of Resident #20's physician's recertification orders dated 7/1/09 documented "...NOVOLIN R...9 UNITS SQ WITH LUNCH...NOVOLIN 70-30...22 UNITS...EVERY MORNING..." A telephone order dated 7/1/09 documented "...Give Regular insulin 8 units before supper...Cont. [continue] sliding scale insulin per protocol for accuchecks..." A physician's progress note dated 7/1/09 documented "...Accucheck low (86) fasting but high rest of time. Will [decrease] Lantus & add fixed dose of insulin..." A progress noted dated 7/22/09 documented "...BGL [blood glucose level] OOC. [out of control] Will ^ 7/30 insulin to 32 units... Cont. Abx [antibiotics]..." A telephone order dated 7/22/09 documented "...Increase morning 70/30 [insulin] to 32 units Continue insulin c [with] meals and basal insulin s [without] change..." A physician's progress note dated 7/27/09 documented "...Pt [patient] sent to ED..."
Emergency Department for dehydration... Na [Sodium] 146... A telephone order dated 7/28/09 documented "... [change] Regular Insulin at Lunch and Dinner to 10 units... [change] SSi to Standard Sliding Scale..." A telephone order dated 7/30/09 documented "...Cont. using standard sliding scale & hold all scheduled insulins until further notice..." A telephone order dated 7/31/09 documented "...insulin 70/30 32 units at breakfast... Lantus 8 units at bedtime... Hold above & scheduled insulin if pt does not eat... Regular insulin 9 units at lunch... Regular insulin 6 units at supper... Do accu [check] TID [three times a day]...

Review of Resident #20's BS flow sheet for July 2009 documented 123 opportunities for BS to be checked. The top of the July 2009 flow sheet for SSi documented "...Call MD if BS < 60 or > 400 Chart on back..." There were 4 opportunities that there was no documentation that a BS was obtained. There were 12 with the wrong doses of insulin given. The BS with the incorrect SSi were as follows:

- a. 7/2/09 at 6:00 PM - BS = 329, Insulin given 0, correct dose 8U.
- b. 7/4/09 at 6:00 AM - BS = 128, Insulin given 2, correct dose 0U.
- c. 7/4/09 at 9:00 PM - BS = 250, Insulin given 6, correct dose 4U.
- d. 7/5/09 at 9:00 PM - BS = 200, Insulin given 4, correct dose 2U.
- e. 7/6/09 at 9:00 PM - BS = 112, Insulin given 2, correct dose 0U.
- f. 7/12/09 at 6:00 AM - BS = 137, Insulin given 2, correct dose 0U.
- g. 7/19/09 at 8:00 AM - BS = 139, Insulin given 2, correct dose 0U.
- h. 7/19/09 at 9:00 PM - BS = 300, Insulin given 8,

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<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 333</td>
<td>Continued From page 42 [Emergency Department for dehydration... Na [Sodium] 146... A telephone order dated 7/28/09 documented &quot;... [change] Regular Insulin at Lunch and Dinner to 10 units... [change] SSi to Standard Sliding Scale...&quot; A telephone order dated 7/30/09 documented &quot;...Cont. using standard sliding scale &amp; hold all scheduled insulins until further notice...&quot; A telephone order dated 7/31/09 documented &quot;...insulin 70/30 32 units at breakfast... Lantus 8 units at bedtime... Hold above &amp; scheduled insulin if pt does not eat... Regular insulin 9 units at lunch... Regular insulin 6 units at supper... Do accu [check] TID [three times a day]...&quot; Review of Resident #20's BS flow sheet for July 2009 documented 123 opportunities for BS to be checked. The top of the July 2009 flow sheet for SSi documented &quot;...Call MD if BS &lt; 60 or &gt; 400 Chart on back...&quot; There were 4 opportunities that there was no documentation that a BS was obtained. There were 12 with the wrong doses of insulin given. The BS with the incorrect SSi were as follows: a. 7/2/09 at 6:00 PM - BS = 329, Insulin given 0, correct dose 8U. b. 7/4/09 at 6:00 AM - BS = 128, Insulin given 2, correct dose 0U. c. 7/4/09 at 9:00 PM - BS = 250, Insulin given 6, correct dose 4U. d. 7/5/09 at 9:00 PM - BS = 200, Insulin given 4, correct dose 2U. e. 7/6/09 at 9:00 PM - BS = 112, Insulin given 2, correct dose 0U. f. 7/12/09 at 6:00 AM - BS = 137, Insulin given 2, correct dose 0U. g. 7/19/09 at 8:00 AM - BS = 139, Insulin given 2, correct dose 0U. h. 7/19/09 at 9:00 PM - BS = 300, Insulin given 8,</td>
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| F 333 | Continued From page 43  

- Correct dose 6U.  
i. 7/24/09 at 6:00 AM - BS = 226, Insulin given 0, correct dose 4U.  
j. 7/24/09 at 4:30 PM - BS = 194, Insulin given 4, correct dose 2U.  
k. 7/25/09 at 6:00 AM - BS = 209, Insulin given 0, correct dose 4U.  
l. 7/27/09 at 4:00 PM - BS = 135, Insulin given 2, correct dose 0U.  
The administration of the wrong doses of insulin resulted in significant medication errors.  
Review of Resident #20's BS done on 7/29/09 at 6:30 AM, documented a BS of 68, and the resident was given 32 units of Novolin 70/30.  
Review of the breakfast meal times for Resident #20 documented the meal trays come to the East hall beginning at 7:50 AM. Review of the nurse's note dated 7/29/09 at 9:58 AM, documented "...Called to room per CNA [Certified Nursing Assistant]; Resident observed sweating, tongue hanging out mouth & unresponsive. BS checked reading "LO" oral gluco [glucagon] given ^ [Increased] BS to 20. IM gluco given ^ BS to 74; MD notified of results said to hold all insulins except SSI... Call back in 1 hr [hour] c [with] BS results..." Review of a physician's progress note dated 7/29/09 at 2:45 PM, documented "...Glucose < 20 this AM...did not eat after 32 units 70/30 [Insulin] this AM. Will [decrease] insulin..." The administration of 32 units of Novolin 70/30 insulin with a low blood sugar of 63 without being given any food resulted in a significant medication error and placed Resident #20 in immediate jeopardy.  
According to the "MED-PASS" provided by the American Society of Consultant Pharmacists, the onset of Novolin 70/30 is "30 min [minutes]... Give | F 333 | | | |
Continued From page 44

approximately 30 minutes before meal. Each dose targets post-prandial blood sugars as well as basal insulin requirements... The breakfast meal was not received for one hour and 20 minutes after the fast acting insulin was administered rather than the thirty minutes recommended. The resident displayed the above documented life-threatening symptoms with a blood sugar of less than 20.

Observations in Resident #20's room on 8/12/09 at 8:15 AM, revealed Resident #20 had just gotten his breakfast tray and was being fed a pureed diet by a CNA.

On 7/18/09 at 12:00 PM Resident #20's BS was 52. There was no documentation of any intervention taken to bring the BS up, and no documentation that the physician was notified of the low BS. The BS on 7/11/09 at 6:00 AM was 69. The resident was given 22 units of Novolin 70/30 and there was no documentation that the resident ate anything.

There were 6 documented BS that were above 400 with no documentation that the BS was rechecked, and no documentation that the physician was notified. The BS were as follows:

a. 7/5/09 at 4:45 PM - BS = 404.

b. 7/10/09 at 4:30 PM - BS = HI.

c. 7/13/09 at 4:00 PM - BS = 473.

d. 7/15/09 at 4:00 PM - BS = 429.

e. 7/18/09 at 4:00 PM - BS = 408.

f. 7/21/09 at 4:00 PM - BS = 403.

Review of Resident #20's BS flow sheet for 8/1/09 through 8/10/09 at 11:45 AM, documented 38 opportunities for BS to be checked. The top of the August 2009 flow sheet for SSI documented
Continued from page 45
"...Call MD if BS < 60 or > 400 Chart on Back..."
There were 2 with the wrong doses of insulin given. The BS with the incorrect SSI were as follows:
a. 8/1/09 at 10:00 PM - BS = 424, Insulin given 0, correct dose 12U.
b. 8/2/09 at 6:00 AM - BS = 215, Insulin given 6, correct dose 4U.
The administration of the wrong doses of insulin resulted in significant medication errors.

Review of the facility "Ordering and Receiving Medications" documented "...New medications, except for emergency or "stat" [now] medications, are ordered as follows...If needed before the next regular delivery, fax/phone the medication orders to the pharmacy immediately upon receipt. Inform the pharmacy of the need for prompt delivery..."Stat" and emergency medications are ordered as follows...During regular pharmacy hours, the emergency or "stat" order is telephoned and faxed to the pharmacy immediately upon receipt. Such medications are delivered and administered within a timely manner...Emergency/STAT medication orders when medication is available in the emergency kit. From the emergency kit, remove the appropriate number of doses to be administered prior to the next regularly scheduled pharmacy delivery...."
F 333  Continued From page 46

11:00...call result to [named MD]..." A telephone order dated 7/31/09 at 3:35 PM, documented Gentamicin peak lab Monday 8/3/09 1 hour after gentamicin IV completed..." A telephone order dated 8/1/09 at 8:04 PM, documented "...initiate 1st [first] dose of Gentamicin..."

Review of a laboratory report dated 8/1/09 for Resident #20 documented Gentamicin trough result "0.3". Review of the nurses' note date 8/1/09 at 6:05 PM, documented "...[named MD] notified of trough (Gentamicin) report 0.3...Inst. [instructed] start Gentamicin..." The note dated 8/1/09 at 8:25 PM, documented "...[named MD] notified Gent. [Gentamicin] did not arrive from pharmacy...MD order to change all previous Gentamicin dose times & labs...Notify MD on call when Gentamicin arrives & is started. Will give MD orders for further doses [doses] & labs. at that time. Call lab results when obtained..."

Review of a physician's telephone order for Resident #20 dated 8/1/09 at 8:25 PM, documented "...DC [discontinue] all previous Gentamicin times & Give IV Gentamicin 1mg/kg dose as soon as it arrives from pharmacy..." A telephone order dated 8/2/09 at 12:15 AM, documented Administer Gentamicin 75mg/100ml [milligrams per milliliter] NS [normal saline] per IV PB [IV piggyback] now q8h [due to] arrival from pharmacy..."

Review of Resident #20's Medication Administration Record (MAR) for July 2009 documented a dose of Gentamicin was given 7/31/09, there was no documentation that a dose was given 7/30/09 as ordered. Review of the MAR for August 2009 documented the next dose of Gentamicin was not given until 12:00 Midnight.
Continued From page 47 on 8/2/09.

During an interview with the Consultant Pharmacist (CP) in the conference room on 8/12/09 at 8:35 PM, the CP was asked when the pharmacy receives an order for a new medication when it sent to the facility. The CP stated, "...the day it is received it should be here...." The CP confirmed that an order for an antibiotic (Gentamycin) would be considered an emergency or "stat" order. The CP was asked if she could find out when the pharmacy received the order for the Gentamycin. The CP brought a written statement that documented, "...Order faxed to pharmacy and also called to pharmacy 9:41 AM... named Pharmacist gave instructions of mixing for IV administration. Med [medication] was taken from the emergency kit [at the facility], 8/1 [8/1/09] called on-call pharmacist 9:26 PM...Pharmacy courier called at 10:03 PM...Medication delivered to [named facility]...11:51 PM...Pharmacy sent following: 7/31...Billed to Emergency Kit...8/1...#3 [doses]...8/2...#3, 8/3...#2...order changed to IM [intramuscular] 8/6...#5..."

During a telephone interview with Resident #20's attending physician on 8/11/09 at 11:45 AM, he stated "...there was an issue with getting Gentamycin... but, I'm sure you've see that...."

Observations in Resident #20's room on 8/12/09 at 8:15 AM, revealed the resident was served a pureed diet of eggs, sausage, oatmeal, and bread pudding.

During a telephone interview with Resident #20's attending physician on 8/11/09 at 11:45 AM, the MD was asked if he would expect the staff to give...
F 333 | Continued From page 48
the scheduled doses of insulin if the BS were in
the 60's or 70's. He stated, "...it would be okay, if
his [resident] eats..." The MD further stated
"...issues with the [BS] logs being completed...
blanks... there is a system's problem...".

Nurse #14 failed to hold Resident #20's
scheduled dose of Novolin 70/30 (70 percent (%)
NPH - long acting insulin, and 30% Regular
insulin - short acting) 32 units after obtaining a BS
of 68 on 7/29/09 at 6:30 AM. Resident #20's
scheduled breakfast time is 7:50 AM, an hour and
20 minutes after the insulin was given. There was
no documentation that the resident was given a
snack at the time the insulin was administered,
and no documentation of follow-up monitoring of
the resident's condition. This resulted in
immediate jeopardy when the resident did not eat
breakfast and was found unresponsive at 9:30
AM with a BS reading of "LO [below 20]". The
facility's staff failure to consistently administer
the wrong doses of insulin, failure to follow
interventions, document follow-ups and failure to
notify the physician of low and elevated BS levels
placed all diabetic residents at risk to their safety
and wellbeing.

6. Medical record review for Resident #4
documented an admission date of 3/8/08 with
diagnoses of Hypertension, Diabetes, Again
Pectonis, Coronary Vessel Aneurysm,
Dehydration and Percutaneous Endoscopic
Gastrostomy. Review of the physician's
recertification orders dated for 4/6/09, 5/11/09,
6/2/09 and 7/5/09 documented, "ACCUCHECKS
DAILY" and no orders for insulin to be
administered. Review of the blood sugar flow
sheet for April 2009 recorded 30 opportunities for
BS to be checked. There were 8 doses of insulin
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<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 333</td>
<td>Continued From page 49</td>
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<tr>
<td></td>
<td>a. 4/3/09 at 6:00 AM - BS = 164, Insulin given = 2 U, no SSI ordered.</td>
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<td>b. 4/10/09 at 6:00 AM - BS = 177, Insulin given = 2 U, no SSI ordered.</td>
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<td>c. 4/12/09 at 6:00 AM - BS = 181, Insulin given = 2 U, no SSI ordered.</td>
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<td>d. 4/15/09 at 6:00 AM - BS = 164, Insulin given = 2 U, no SSI ordered.</td>
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<td>e. 4/23/09 at 6:00 AM - BS = 157, Insulin given = 2 U, no SSI ordered.</td>
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<td>f. 4/24/09 at 6:00 AM - BS = 184, Insulin given = 2 U, no SSI ordered.</td>
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<td>g. 4/28/09 at 6:00 AM - BS = 164, Insulin given = 2 U, no SSI ordered.</td>
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<tr>
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<td>h. 4/30/09 at 6:00 AM - BS = 169, Insulin given = 2 U, no SSI ordered.</td>
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<td></td>
<td>The administration of insulin with no physician's order resulted in significant medication errors.</td>
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Review of the blood sugar flow sheet for May 2009 recorded 31 opportunities for BS to be checked. There were 14 doses of insulin given.

<table>
<thead>
<tr>
<th>ID TAG</th>
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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<tbody>
<tr>
<td>F 333</td>
<td>Continued From page 50</td>
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<tr>
<td></td>
<td>i. 5/20/09 at 6:00 AM - BS = 162, Insulin given = 2 U, no SSI ordered.</td>
</tr>
<tr>
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<td>j. 5/22/09 at 6:00 AM - BS = 160, Insulin given = 2 U, no SSI ordered.</td>
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<td>k. 5/24/09 at 6:00 AM - BS = 167, Insulin given = 2 U, no SSI ordered.</td>
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<tr>
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<td>l. 5/25/09 at 6:00 AM - BS = 188, Insulin given = 2 U, no SSI ordered.</td>
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<tr>
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<td>m. 5/27/09 at 6:00 AM - BS = 186, Insulin given = 2 U, no SSI ordered.</td>
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<td>n. 5/30/09 at 6:00 AM - BS = 164, Insulin given = 2 U, no SSI ordered.</td>
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<td>The administration of insulin with no physician's order resulted in significant medication errors.</td>
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<td></td>
<td>Review of the blood sugar flow sheet for June 2009 recorded 30 opportunities for BS to be checked.</td>
</tr>
<tr>
<td></td>
<td>a. 6/3/09 at 6:00 AM - BS = 166, Insulin given = 2 U, no SSI ordered.</td>
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<td>b. 6/5/09 at 6:00 AM - BS = 168, Insulin given = 2 U, no SSI ordered.</td>
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<td>c. 6/12/09 at 6:00 AM - BS = 162, Insulin given = 2 U, no SSI ordered.</td>
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<td>d. 6/14/09 at 6:00 AM - BS = 166, Insulin given = 2 U, no SSI ordered.</td>
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<td>e. 6/19/09 at 6:00 AM - BS = 154, Insulin given = 2 U, no SSI ordered.</td>
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<td>f. 6/21/09 at 6:00 AM - BS = 191, Insulin given = 2 U, no SSI ordered.</td>
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<td>g. 6/22/09 at 6:00 AM - BS = 156, Insulin given = 2 U, no SSI ordered.</td>
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<td>h. 6/24/09 at 6:00 AM - BS = 152, Insulin given = 2 U, no SSI ordered.</td>
</tr>
<tr>
<td></td>
<td>i. 6/28/09 at 6:00 AM - BS = 150, Insulin given = 2 U, no SSI ordered.</td>
</tr>
<tr>
<td></td>
<td>j. 6/29/09 at 6:00 AM - BS = 185, Insulin given = 4 U, no SSI ordered.</td>
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
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order resulted in significant medication errors.

7. Medical record review for Resident #10 documented an admission date of 4/29/09 with diagnoses of Alzheimer's Disease, Dementia, Diabetes Mellitus, Peripheral Edema, and Depressive Disorder. Review of a physician's recertification order dated 6/9/09 documented, "NOVOLIN R 100 UNITS/ML [milliliter] AS DIRECTED ACCORDING TO SLIDING SCALE. SLIDING SCALE <60, call MD, HOLD ANY SCHEDULED INSULIN UNTIL VERIFIED WITH MD. 150-200 = 2 UNITS, 201-250 = 4 UNITS, 251-300 = 6 UNITS, 301-350 = 8 UNITS, 351-400 = 10 UNITS > 401 = 12 UNITS, RECHECK IN 2 HOURS AND IF STILL > 401, CALL MD..." Review of the Accucheck/Insulin Log documented the 6/4/09 at 5:00 PM - BS was 150 with no insulin given, the correct insulin dose to be administered was 2U. The failure to administer insulin as ordered resulted in a significant medication error.

8. Medical record review for Resident #11 documented an admission date of 7/31/07 with diagnoses of Alzheimer's Disease, Dementia, Prostate Cancer, Depression, Insomnia, Seizure Disorder, Osteoarthritis, Adult Failure to Thrive, and Diabetes Mellitus. Review of the physician’s order initiated 1/1/09 documented "...ACCUCHECKS BEFORE MEALS AND AT BEDTIME ...6AM,...11AM...4:30 PM...9PM... SLIDING SCALE (REGULAR) 150 - 200 = 4 UNITS...201 - 250 = 6 UNITS...251 - 300 = 8 UNITS...301 - 350 = 10 UNITS...351 - 400 = 12 UNITS...401 - 450 = 14 UNITS...> 450 = 16 UNITS...CALL MD FOR BS > 450..." Review of the BS flow sheet for May 2009 recorded 124 opportunities for the BS to be checked. There...
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<td>F 333</td>
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were 8 with the wrong dose of insulin given, and
the BS was not check on 5/29/09 at 9:00 PM. The
BS with the incorrect SSI were as follows:
a. 5/4/09 at 11:00 AM - BS = 152, Insulin given =
2, correct dose = 4U.
b. 5/10/09 at 11:00 AM - BS = 150, Insulin given =
0, correct dose = 4U.
c. 5/15/09 at 11:00 AM - BS = 251, Insulin given =
6, correct dose = 8U.
d. 5/18/09 at 11:00 AM - BS = 169, Insulin given =
0, correct dose = 4U.
e. 5/21/09 at 11:00 AM - BS = 150, Insulin given =
2, correct dose = 4U.
f. 5/26/09 at 5:00 PM - BS = 152, Insulin given =
2, correct dose = 4U.
The failure to administer insulin as ordered
resulted in a significant medication errors.

Review of the BS flow sheet for 6/1/09 through
6/6/09 documented 11 opportunities for the BS to
be checked. The resident was in the hospital from
6/2/09 through 6/5/09 AM. There were 2 with the
wrong dose of insulin given. The BS with the
incorrect SSI were as follows:
a. 6/1/09 at 6:30 AM - BS = 150, Insulin given = 0,
correct dose = 4U.
b. 6/2/09 at 6:30 AM - BS = 161, Insulin given = 2,
correct dose = 4U.
The failure to administer insulin as ordered
resulted in a significant medication errors.

Review of the physician's hospital return orders
dated 6/10/09 documented "...ACCUCHEKS
EVERY 6 HOURS ...6AM...12NOON...6PM...
12MID [midnight]... SLIDING SCALE (REGULAR)
<200 = NO INSULIN...201 - 250 = 2 UNITS...251
- 300 = 4 UNITS...301 - 350 = 6 UNITS...351-
400 = 8 UNITS...>400 = 10 UNITS AND
RECHECK IN 1 HOUR..." Review of the BS flow
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Continued From page 53

sheet for July 2009 recorded 124 opportunities for the BS to be checked. The BS on 7/18/09 at midnight was not obtained.

9. Medical record review for Resident #17 documented an admission date of 9/28/05 with diagnoses of Diabetes Mellitus, Seizures, Chronic Airway Obstruction and Alcoholic Dementia. Review of a physician's order dated 7/5/09 documented, "...Accuchek Bld [two times a day]. Novolin R [regular] 10 units sq [subcutaneous] Tid [three times a day] 30 minutes AC [before meals]."

Observations in Resident #17's room on 8/3/09 at 4:03 PM, revealed Nurse #3 administered Novolin R 8 units in the right abdomen. Resident #17's evening meal tray was not served until 5:17 PM. Resident #17 took the first bite of the meal at 5:22 PM, 1 hour and 19 minutes after administration of the insulin. Resident #17 was not given the correct amount of insulin as ordered by the physician. This resulted in a significant medication error.

10. Medical record review for Resident #18 documented an admission date of 7/18/07 with diagnoses of Organic Brain Syndrome, Diabetes Mellitus, Hypertension, and Hyperlipidemia. Review of the physician's orders dated 7/5/09 documented, "ACCUCHECKS BEFORE MEALS...6:30 AM...11 AM...4:30 PM...NOVOLIN R 100 UNITS/ML AS DIRECTED ACCORDING TO SLIDING SCALE. SLIDING SCALE (REGULAR) 60-100= ORANGE JUICE 101-250= NO INSULIN 151-200= 2 UNITS 201-250= 4 UNITS 251-300= 6 UNITS 301-350= 8 UNITS 351-400= 10 UNITS > 401 = NOTIFY MD..." and no physician's orders for insulin to be
F 333  | Continued From page 54 administered.

Observations during medication administration in Resident #18's room on 8/3/09 at 4:15 PM, revealed Nurse #10 administered Novolin R 12 units for a BS of 432 without notifying the physician and without an order for the insulin. The administration of insulin without a physician's order resulted in a significant medication error.

During an interview in the conference room on 8/6/09 at 2:40 PM, the DON stated, "...they [staff] document on the back of the blood sugar sheet [notification of MD]..."

11. Medical record review for Resident #19 documented an admission date of 7/27/09 with diagnoses of Prostate Cancer, Depression, Gout, Osteoarthritis, Seizure Disorder, Peripheral Vascular Disease, Hypertension, Coronary Artery Disease, and Diabetes Mellitus. Review of a hand-written, unsigned order for 7/27/09 through 7/31/09 documented "...Accucheks AC & HS c Novolog SSI..." There was no documentation of a signed physician's order for SSI. Review of the BS flow sheets for 7/27/09 through 8/5/09 at lunch documented 34 times that the BS was checked. There were 23 times that SSI was given to the resident. The resident's blood sugars ranged from 150 with 2 units of insulin given, to 275 with 6 units of insulin given.

Observations in Resident #19's room on 8/3/09 at 4:10 PM, revealed Nurse #3 administered 4 units of Novolog to the resident without a physician's order. The administration of insulin without a physician's order resulted in a significant medication error.
F 333  Continued From page 55

12. Closed medical record review for Resident #24 documented an admission date of 6/5/09 with diagnoses of Stroke, Diabetes Mellitus, and Hematuria. Review hand-written unsigned physician's order dated 6/11/09 documented, "...Blood Sugar q [every] 6 hours x 1 wk [week] notify MD ...Novolin 70/30 15 Units SQ at 8:00 am...8:00pm..." Review of the Accucheck/Insulin Log dated for 6/11/09 at 6:00 PM through 6/17/09 at 12:00 Midnight documented 26 opportunities for the BS to be checked. There were 7 times that SSI was given to the resident according the the scale at the top of the Accucheck/Insulin Log without a signed physician's order. The resident's BS ranged from 153 with 2 units of insulin given to 187 with 2 units of Insulin given. Review of the Accucheck/Insulin Log for Novolin 70/30 documented 20 times that Novolin 70/30 15 units was administered without a signed order, and 2 Units of regular insulin was administered on 6/23/09 at 8:00 PM without an order. There was no signed physician's order to give sliding scale insulin or scheduled insulin. The administration of insulin without a physician's order resulted in a significant medication errors.

13. Medical record review for Resident #26 documented an admission date of 12/18/08 with diagnosis that included Organic Brain Syndrome, Alzheimer's, Diabetes Mellitus, Osteoarthritis, Atrial Fibrillation, Peripheral Vascular Disease and Left Below the Knee Amputation. Review of the signed May 2009 recertification orders documented an order for accuchecks AC and HS with SSI to be administered per protocol. Review of the May 2009 Accuchecks/Insulin Log documented the resident had orders for accuchecks before meals at 6:30 AM, 11:00 AM, 4:30 PM, and at 8:00 PM. Review of the May...
F 333 Continued From page 56

2009 Accucheck/Insulin Log revealed there was no documentation the accuchecks were performed on 5/30/09 and 5/31/09 at HS.

14. Medical record review for Resident #29 documented an admission date of 10/23/07 with a diagnosis of Diabetes Mellitus, Hypertension, Alzheimer's Disease, and Hypertrophy of Prostate. Review of a physician's order initiated 8/18/08 documented, "...ACCUCHECKS TWICE DAILY 6:30 AM 4:30 PM SLIDING SCALE (REGULAR)...60-100 = OJ [orange juice]...101-150 = NO INSULIN...151-200 = 2 UNITS..." An order dated 6/16/09 documented "...LANTUS 40 UNITS SQ AT BEDTIME..."

Review of the accucheck/insulin log for June 2009 documented the resident received Insulin according to the sliding scale at the top of the Accucheck/Insulin Log sheet "...Standard Sliding Scale...150-200 Give 2 units of Regular insulin..."

There were 80 opportunities for the BS to be obtained with the following discrepancies:

a. 6/5/09 at 6:00 AM - BS = 150, Insulin given 2, correct dose was 0U.

b. 6/3/09 at 4:30 PM - No BS obtained.

c. 6/30/09 at 8:00 PM - Scheduled Lantus not given.

The failure to administer insulin as ordered resulted in a significant medication errors.

15. Medical record review for Resident #32 documented an admission date of 4/23/09 and a re-admission date of 5/15/09 with diagnoses of Congestive Heart Failure, Hypertension, Urinary Tract Infection, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, and Status Post Left Below the Knee Amputation. Review of a physician's order dated 5/15/09 documented, "...Change Novolog Insulin to Novolin R and use..."
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:** 445366

**(X2) MULTIPLE CONSTRUCTION**
- A. BUILDING ________
- B. WING ________

**(X3) DATE SURVEY COMPLETED:** 08/12/2009

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**TENNESSEE STATE VETERANS HOME**

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

2866 MAIN STREET
HUMBOLDT, TN 38343

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<tr>
<td>F 333</td>
<td>Continued From page 57 SSI per Protocol/Accucheks AC (before meals) and HS (bedtime). &quot;Review of the physician's order for 7/8/09 documented, &quot;...ACCUECHECKS BEFORE MEALS AND AT BEDTIME... [administer] SLIDING SCALE PER PROTOCOL.&quot; Review of the BS flow sheet for June 2009 documented 120 opportunities for the BS to be obtained. On 8/2/09 at 11:00 AM revealed no BS was obtained. Review of the July 2009 BS flow sheet documented 124 opportunities for the BS to be obtained. There was 1 opportunity that the wrong dose of insulin was given. The BS on 7/28/09 at 8:00 AM was 89, with 4 units of insulin administered, the correct dose was for no insulin to be administered. The failure to administer insulin as ordered resulted in a significant medication errors. 16. Medical record review for Resident #34 documented an admission date of 5/14/09 with diagnoses of Diabetes Mellitus, Hypertension, Seizures, Aortic Stenosis, Congestive Heart Failure, and Suspected Meningitis. Review of a physician's order dated 6/04/09 documented, &quot;...Accuchek AC and HS...Standard sliding scale insulin: &lt;60 call MD and hold any Scheduled insulin until call MD...150-200 =2 Units Reg. Insulin SQ...201-250 = 4 Units Req [Regular]. Insulin SQ...251-300 =8 Units Req. Insulin SQ...301-350 = 8 Units Reg. Insulin SQ...351-400 =10 Units Reg. Insulin SQ...&gt; 400 =12 Units Reg. Insulin SQ...recheck in 2 hours and if still &gt;401 call MD...&quot; Review of the BS flow sheet for June 2009 documented 108 opportunities for BS to be obtained. There were 8 opportunities with discrepancies as follows: a. 6/6/09 at 9:00 PM - BS not obtained.</td>
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<td>TENNESSEE STATE VETERANS HOME</td>
<td>2866 MAIN STREET</td>
</tr>
<tr>
<td></td>
<td>HUMBOLDT, TN 38343</td>
</tr>
</tbody>
</table>

<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>
<th>ID PREFIX TAG</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>
</table>
| F 333         | Continued From page 58[b. 6/7/09 at 6:30 AM - BS = 151, Insulin given 0, correct dose 2 U. c. 6/14/09 at 6:30 AM - BS not obtained. d. 6/14/09 at 9:00 PM - BS not obtained. e. 6/17/09 at 6:30 AM - BS = 159, Insulin given 0, correct dose 2 U. f. 6/22/09 at 6:30 AM - BS = not obtained. The failure to administer insulin as ordered resulted in significant medication errors. Review of a physician's order initiated on 6/18/09 documented, "...Accuchek Twice Daily... Standard sliding scale insulin..."
Review of the July 2009 Accuchek/Insulin Log documented 62 opportunities for BS to be obtained. There were 7 opportunities with no SSI given as ordered. They were as follows: a. 7/5/09 at 6:00 AM - BS = 190, Insulin given = 0, correct dose 2 U. b. 7/7/09 at 6:00 AM - BS = 204, Insulin given = 0, correct dose 4 U. c. 7/13/09 at 6:00 AM - BS = 162, Insulin given = 0, correct dose 2 U. d. 7/16/09 at 5:00 PM - BS = not done. e. 7/20/09 at 5:00 PM - BS = not done. f. 7/26/09 at 6:00 AM - BS = not done. g. 7/27/09 at 6:00 AM - BS = not done. The failure to administer insulin as ordered resulted in significant medication errors. 17. Medical record review for Resident #35 documented an admission date of 12/29/06 with diagnoses of Diabetes Mellitus, Seizure Disorder, Hypertension, Paranoid Schizophrenia, Depression, Glaucoma and Anxiety. Review of the physician's recertification orders dated 5/14/09, 6/9/09 and 7/5/09 documented, "ACCUCHECKS BEFORE MEALS AN AT
**continued from page 59**

- **Bedtime**: 6AM...11AM...4:30PM...9PM...Sliding Scale <60 = OJ W/2 PKTS [packets] SUGAR FOLLOWED BY OJ W/1 PKT SUGAR, PER DR. [named physician] 150-200 =2 UNITS, 201-250 = 4 UNITS, 251-300 = 6 UNITS, 301-350 = 8 UNITS, 351-400 = 10 UNITS >400 = 12 UNITS, RECHECK IN 2 HOURS, IF STILL >401, CALL MD... "Review of the BS flow sheet for May 2009 documented 124 opportunities for the BS to be checked. There was no BS obtained on 5/30/09 at 6:30 AM. Review of the BS flow sheet June 2009 documented 120 opportunities for the BS to be checked. There were no BS obtained on 6/26/09 at 11:00 AM and 6/30/09 at 4:30 PM. Review of the BS flow sheet for July 2009 documented 124 opportunities for the BS to be obtained. There were no BS obtained on 7/7/09 at 9:00 PM and 7/29/09 at 8:00 AM.

18. Medical record review for Resident #36 documented an admission on 9/11/08 with diagnoses of Coronary Artery Disease, Atrial Fibrillation, Obesity, Peripheral Vascular Disease, Anemia, Decubitus Ulcer, Chronic Pain, and Diabetes Mellitus. Review of a physician’s order initiated 7/21/08 and current orders of 7/5/09 for documented "...SLIDING SCALE (REGULAR) 80 - 100 = OJ...101 - 150 = NO INSULIN...151 - 200 = 2 UNITS...201 - 250 = 4 UNITS...251 - 300 = 6 UNITS...301 - 350 = 8 UNITS...351 - 400 = 10 UNITS...NOTIFY MD IF BS >401..." An order initiated 10/1/08 and current order dated 7/5/09 documented "...ACCUCHECKS DAILY...". Review of the BS flow sheet for 5/3/09 through 5/31/09 documented 29 opportunities for BS to be checked. The 5/3/09 at 6:00 AM BS was 302, with 6 units of insulin administered. The correct insulin dose was 30U. Review of the July 2009 BS flow sheet documented 31 opportunities for BS to be
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(x4) 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) |
--- | --- | --- | --- |
F 333 | Continued From page 60 checked. The 7/25/09 at 6:30 AM BS was 176, with no insulin administered. The correct insulin dose was 2U. Review of the 8/1/09 through 8/5/09 BS flow sheet documented 5 opportunities for BS to be checked. The 8/1/09 at 6:00 AM BS was 152, with 6U of insulin administered. The correct insulin dose was 2U. The 8/3/09 at 6:00 AM BS was 158, with 6U of insulin administered. The correct insulin dose was 2U. The failure to administer insulin as ordered resulted in significant medication errors.

19. Medical record review for Resident #37 documented an admission date of 11/17/08 with diagnoses of Congestive Heart Failure, Cerebral Vascular Disease, Peripheral Vascular Disease, Organic Brain Syndrome, Benign Prostate Hypertrophy, Obesity, Hypertension, Overactive Bladder, and Hyperglycemia. Review of the physician's orders initiated 3/3/09 documented "...ACCUCHECKS BEFORE MEALS AND AT BEDTIME...SEE DM [Diabetes Mellitus] FLOW SHEET [for times] 6:30 AM, 11:00 AM, 5:00 PM and 9:00 PM...SLIDING SCALE (REGULAR)...0 - 60 = 1 AMP [ampule] D5W [Dextrose 5 percent in Water], CALL MD...61 - 150 = NO INSULIN, 151 - 200 = 1 UNIT...201 - 250 = 2 UNITS...251 - 300 = 3 UNITS...301 - 350 = 4 UNITS...351 - 400 = 5 UNITS... >400 = 6 UNITS, RECHECK & CALL MD IF STILL ABOVE >400..."

Review of the May 2009 BS flow sheet documented BS were done at 6:00 AM, 11:00 AM, 5:00 PM, and 8:00 PM. There were 124 opportunities for BS to be checked with the following discrepancies noted:

a. 5/2/09 at 8:00 PM - BS = 153, Insulin given = 0, correct dose = 2U.
b. 5/3/09 at 8:00 PM - BS = 338, Insulin given = 6U.

STREET ADDRESS, CITY, STATE, ZIP CODE
2666 MAIN STREET
HUMBOLDT, TN 38343

DATE SURVEY COMPLETED
08/12/2009
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<tbody>
<tr>
<td>F 333</td>
<td>Continued From page 61</td>
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<tr>
<td></td>
<td>10, correct dose 8 U.</td>
</tr>
<tr>
<td></td>
<td>c. 5/30/09 at 8:00 PM = No accuchek obtained.</td>
</tr>
<tr>
<td></td>
<td>The failure to administer insulin as ordered resulted in significant medication errors.</td>
</tr>
<tr>
<td></td>
<td>Review of the BS flow sheet for June 2009 documented the BS were done at 6:00 AM, 11:00 AM, 5:00 PM, and 9:00 PM. There were 120 opportunities for BS to be checked with the following discrepancies noted:</td>
</tr>
<tr>
<td></td>
<td>a. 6/4/09 at 11:00 AM - BS = 234, Insulin given = 0, correct dose = 4 U.</td>
</tr>
<tr>
<td></td>
<td>b. 6/25/09 at 11:00 AM - BS = 210, Insulin given = 2, correct dose = 4 U.</td>
</tr>
<tr>
<td></td>
<td>The failure to administer insulin as ordered resulted in significant medication errors.</td>
</tr>
<tr>
<td></td>
<td>Review of the BS flow sheet for 8/1/09 through 8/6/09 at 11:00 AM documented 22 opportunities for BS to be obtained with the following discrepancies noted:</td>
</tr>
<tr>
<td></td>
<td>a. 8/5/09 at 11:00 AM - BS = 212, Insulin given = 0, correct dose = 4 U.</td>
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<tr>
<td></td>
<td>The failure to administer insulin as ordered resulted in significant medication errors.</td>
</tr>
<tr>
<td></td>
<td>20. Medical record review for Resident #38 documented an admission date on 2/28/08 with diagnoses of Hypertension, Hyperlipidemia, Cerebral Vascular Disease, Brain Neoplasm, Onychomycosis, Anemia, and Diabetes Mellitus. Review of the physician's orders initiated 2/4/09 documented &quot;...ACCUCHECKS BEFORE MEALS, THREE TIMES DAILY...6AM...11AM...4:30 PM...NOVOLIN R...AS DIRECTED ACCORDING TO SLIDING SCALE...SLIDING SCALE &lt;60, CALL MD, HOLD ANY SCHEDULED INSULIN UNTIL VERIFIED WITH MD...150 - 200 = 2 UNITS...201 - 250 = 4 UNITS...251 - 300 = 6&quot;</td>
</tr>
</tbody>
</table>
F 333 Continued From page 62

UNIT...301 - 350 = 8 UNITS...351 - 400 = 10
UNIT...401 = 12 UNITS, RECHECK IN 2
HOURS, IF STILL >401, CALL MD..."An order
initiated 5/21/09 documented "...NOVOLIN N...9
UNIT SQ AT 6AM AND 7 UNITS AT 4PM..."

Review of the BS flow sheet for May 2009
documented 93 opportunities for BS to be
obtained with the following discrepancies noted:
  a. 5/8/09 at 11:00 AM - BS = 150, Insulin given =
     0, correct dose 2U.
  b. 5/8/09 at 5:00 PM - BS = 228, Insulin given = 2,
     correct dose 4U.
  c. 5/12/09 at 6:30 AM - BS = 208, Insulin given =
     2, correct dose 4U.
  d. 5/20/09 at 11:00 AM = No accucheck obtained.
  e. 5/25/09 at 6:30 AM - BS = 207, Insulin given =
     0, correct dose 4U.

The failure to administer insulin as ordered
resulted in significant medication errors.

Review of the BS flow sheet for June 2009
documented 90 opportunities for BS to be
obtained with the following discrepancies noted:
  a. 6/2/09 at 6:00 AM - BS = 160, Insulin given = 0,
     correct dose 2U.
  b. 6/20/09 at 5:00 PM - BS = 92, Schedule dose
     of Novolin N not given.

The failure to administer insulin as ordered
resulted in significant medication errors.

Review of the BS flow sheet for July 2009
documented 93 opportunities for BS to be
obtained. The 7/7/09 at 6:00 AM BS was 200,
with 4U insulin given. The correct insulin dose
was 2U. The failure to administer insulin as
ordered resulted in significant medication errors.

21. Medical record review for Resident #40
F 333  Continued From page 63
documented an admission date of 6/3/08 with
diagnoses of Diabetes, Vascular Dementia and
Depressive Disorder. Review of the physician's
re-certification orders dated for 6/14/09, 6/9/09
and 7/5/09 documented, "ACCUCHECKS FOUR
TIMES DAILY ...6AM...11AM...4:30PM...8PM...
SLIDING SCALE (REGULAR) ...150-200 = 2
UNITS ...201-250 = 4 UNITS ...251-300 = 6
UNITS ...301-350 = 8 UNITS ...351-400 = 10
UNITS ...401-450 = 12 UNITS ...>450 = 14
UNITS AND CALL MD." Review of the May
2009 BS flow sheet recorded 124 opportunities
for the BS to be checked. There was no
documentation the 5/4/09 BS had been obtained.
Review of the June 2009 BS flow sheet recorded
120 opportunities for the BS to be checked. There
was no documentation the 6/29/09 at 11:00 AM
and 6/30/09 at 11:00 BS had been obtained.
Review of the July 2009 BS flow sheet recorded
124 opportunities for BS to be checked. There
was no documentation the 7/20/09 at 6:00 AM BS
had been obtained.

22. Medical record review for Resident #42
documented an admission on 1/8/07 with
diagnoses of Alzheimer's Disease, Esophageal
Reflux, Hypertension, Dementia, Depression,
Anxiety, and Diabetes Mellitus. Review of the
physician's orders initiated 2/21/07 and renewed
on 5/14/09 documented "...ACCUCHECKS ON
WEDNESDAYS BEFORE BREAKFAST AND AS
NEEDED..." An order initiated 10/1/08 and
renewed on 5/14/09 documented "...IF BS <80,
GIVE ORANGE JUICE W/2 PKGS SUGAR,
RECHECK IN 30 MINS [minutes], NOTIFY IF
ABNORMAL CONT. [continues] ...NOTIFY MD IF
>401 UNLESS OTHERWISE SPECIFIED BY
MD." There was no order documented for SSI.
Review of the May 2009 BS flow sheet documented 4 opportunities for the BS to be obtained with the following discrepancies noted:

a. 5/20/09 at 6:15 AM - BS = 192, Insulin given 2, no SSI ordered.
b. 5/27/09 at 6:45 AM - BS = 177, Insulin given 2, no SSI ordered.

Review of the BS flow sheet for June 2009 documented the following:

a. 6/3/09 at 6:00 AM - BS = 162, Insulin given 2, no SSI ordered.

The administration of insulin with no physician's order resulted in significant medication errors.

A physician's order initiated 6/3/09 and continued on 7/5/09 documented "...ACCUCHECKS TWICE DAILY...6AM...11AM...NOVOLIN R...AS DIRECTED ACCORDING TO SLIDING SCALE...SLIDING SCALE (REGULAR)...<60, CALL MD, HOLD ANY SCHEDULED INSULIN UNTIL VERIFIED WITH MD...150 - 200 = 2 UNITS...201 - 250 = 4 UNITS...251 - 300 = 6 UNITS...301 - 350 = 8 UNITS...351 - 400 = 10 UNITS...401 = 12 UNITS, RECHECK IN 2 HOURS, IF STILL >401, CALL MD...".

Review of the July 2009 BS flow sheet documented 62 opportunities for the BS to be obtained with the following discrepancies:

a. 7/5/09 at 4:30 PM - BS 150, Insulin given 0, correct dose 2U.
b. 7/12/09 at 8:30 AM - BS 209, Insulin given 2, correct dose 4U.
c. 7/26/09 at 4:30 PM - BS 201, Insulin given 2, correct dose 4U.

The failure to administer insulin as ordered resulted in significant medication errors.

23. Medical record review for Resident #43 documented an admission date of 6/19/09 with
**TENNESSEE STATE VETERANS HOME**

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

2865 MAIN STREET
HUMBOLDT, TN 38343

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>F 333</td>
<td>Continued From page 65</td>
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- Diagnoses of Hypercholesterolemia, Dementia, Depression, Hypertension and Diabetes. Review of a physician's order dated 5/21/09 documented, administer "SSI per Protocol". Review of the May 2009 BS flow sheet recorded 11 opportunities for BS to be checked. There was no documentation on 5/30/09 at 6:30 AM that the BS had been obtained. Review of a physician's order dated 6/17/09 documented, "Change accucheck to MWV [Monday, Wednesday and Friday] alternating times..." Review of the June 2009 BS flow sheet recorded 41 opportunities for BS to be checked. There was no documentation on 6/22/09 (Monday) at 11:00 AM that the BS was obtained.

24. Medical record review for Resident #46 documented an admission date of 5/14/09 with diagnoses of Pulmonary Embolism, Lumbago, Organic Brain Syndrome, Hyperlipidemia, Benign Prostate Hypertrophy, Peripheral Vascular Disease, Depression, Dementia, and Diabetes Mellitus. Review of the physician's order initiated 5/2009 documented "...ACCUCHECKS TWICE DAILY BEFORE BREAKFAST AND BEFORE SUPPER...6AM...4:30PM...NO SLIDING SCALE... NOVOLIN N...20 UNITS SQ BEFORE BREAKFAST AND 10 UNITS BEFORE SUPPER...".
F 333 Continued From page 66
obtained with the following discrepancies:

a. 7/21/09 at 4:00 PM - BS 189, Insulin given 2, no SSI ordered.
b. 7/22/09 at 4:00 PM - BS 176, Insulin given 2, no SSI ordered.

The administration of sliding scale insulin with no
physician's orders resulted in significant
medication errors.

25. The nursing staff failed to obtain BS as
ordered, failed to administer correct dosages of
SSI as ordered, failed to administer insulin within
30 minutes of meals and/or failed to obtain signed
orders for insulin administration for Residents #4,
10, 11, 17, 18, 19, 20, 24, 28, 29, 32, 34, 35, 36,
37, 38, 40, 42, 43 and 46. The failure to
administer insulin as ordered, to obtain BS as
ordered, or notify the physician of BS below 60
and/or above 401 placed all diabetic residents in
immediate jeopardy.

The immediate jeopardy existed from 7/29/09 to
8/12/09.

On 8/12/09 the facility presented the survey team
an acceptable allegation of compliance as
follows:

a. On 8/5/09 the Staff Development Coordinator,
conducted an Inservice with all Licensed Nurses
regarding insulin administration, facility policy and
procedure for blood glucose checks, insulin
protocol and physician notification of blood
glucoses below 60 and above 400. On 8/5/09 the
facility Medical Director and two attending
physicians re-approved the facility insulin
protocol.
b. On 8/6/09 the attending physicians were
notified of errors by the Management Nurses. On
8/6/09, the Staff Development Nurse began an
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

445386

(2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(3) DATE SURVEY COMPLETED
08/12/2009

NAME OF PROVIDER OR SUPPLIER:
TENNESSEE STATE VETERANS HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
2855 MAIN STREET
HUMBOLDT, TN 38343

| (6) ID. |
| PREFIX |
| TAG    |

| (6) ID. |
| PREFIX |
| TAG    |

| SUMMARY STATEMENT OF DEFICIENCIES |
| (EACH DEFICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION) |
| F 333 |

Continued From page 67

- In-depth inservice for all Licensed Nurses regarding Medication Administration and Diabetes and Insulin Administration. A re-education will take place within 3 months conducted by the Tennessee State Veterans Home University training system. Educational content was approved by the Medical Director. On 8/6/09 the facility Management Nurses began the process of clarifying/verifying all insulin orders for accuracy. 100 percent (%) of all residents had received clarification/verification by 8/7/09.

- On 8/10/09 the facility Management Nurses began observing Licensed Nurses perform blood glucose checks and insulin administration.

- On 8/11/09 a skills fair was conducted by the Staff Development Masters prepared Registered Nurse and sister facility Certified Diabetic Educator. The content included insulin administration with return demonstration, physician notification, professional standards and facility policy for insulin administration and blood glucose checks with return demonstration.

- On 8/12/09, the Staff Development Coordinator re-educated all Licensed Nurses regarding professional standards of care.

- The Admissions Coordinator will alert the Director of Nurses of all new Diabetic admissions, regardless of type of Diabetes. A log will be kept of notification. The Director of Nurses or designee will audit all new admissions for order transcription accuracy, blood glucose checks/insulin log accuracy and physician notification when blood glucose is outside the prescribed parameters. Newly admitted Diabetics will be audited at 100 percent (%) for 3 months.

- The Director of Nurses or designee will report findings to Quality Improvement Committee for review. The committee will reserve the right to extend the auditing timeframe.
Continued From page 68

**g.** The Director of Nurses or designee(s) will audit 100% of all Diabetic medical records for accuracy and physician notification weekly times 4 then monthly for 3 months and report finding to Quality Improvement Team for review. The Regional Nurses will review at least 15 Diabetic medical records monthly and findings will be reported to the facility Administrator, Director of Nurses and Executive Director.

**h.** Resident #20 was examined by the facility Medical Director and attending physician on 8/12/09. A plan of care was updated and agreed upon by facility Medical Director and attending physician.

**i.** The Pharmacy Consultant will continue to perform monthly medication pass observations with emphasis on Insulin Administration. This will continue for 8 months or as needed.

**j.** The facility Compliance Nurse, Quality Improvement Nurse and Staff Development Coordinator will perform monthly medication pass reviews on alternating shifts for 3 months and then quarterly as part of an on-going Quality Improvement Plan. The results of the medication passes will be reported to the Quality Improvement Team for review.

After receiving the facility’s acceptable allegation of compliance the surveyors verified that the corrective actions had been put in place to abate the immediate jeopardy. The surveyors verified the corrective actions by conducting an additional medication administration pass for observations of correct insulin administration and timely meal service, observed facility administrative staff monitoring nurses administering medications, reviewed Inservice records and interviewed staff to verify the staffs knowledge of information received during the inservices. The immediate
### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID</th>
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<th>Description</th>
<th>Resolution</th>
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<tbody>
<tr>
<td>F 333</td>
<td></td>
<td>Continued From page 69. Jeopardy was abated as of 8/12/09. The facility</td>
<td>The facility will develop and implement an infection control program designed</td>
</tr>
<tr>
<td>F 441</td>
<td></td>
<td>483.65(a) Infection Control</td>
<td>The findings included:</td>
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<tr>
<td>S9-D</td>
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<td></td>
<td>1. Review of the facility “Equipment and Supplies Used For Glucose Monitoring” policy documented, “...1. If the surface of the glucose monitor gets dirty, you may clean it. Use a damp cloth and mild soap...”.</td>
</tr>
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<td></td>
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<td></td>
<td>2. Observations in Resident #29’s room on 8/11/09 at 6:30 AM, revealed Nurse #16 offered Resident #29 a package of peanut butter and crackers after obtaining theaccuchek. Nurse</td>
</tr>
</tbody>
</table>
**TENNESSEE STATE VETERANS HOME**

**SUMMARY STATEMENT OF DEFICIENCIES**

*Continued From page 70*

#16 dropped the glucometer machine on the floor, picked it up and then opened the package of crackers. Nurse #6 did not clean the machine before going to the next resident.

3. Observations in Resident #42’s room on 8/11/09 at 6:37 AM, revealed Nurse #17 laid the glucometer on Resident #42’s overbed table. Nurse #17 washed her hands picked the glucometer up and then laid the glucometer on Resident #42’s bed. The nurse did not clean the glucometer.

483.85(b)(3) PREVENTING SPREAD OF INFECTION

The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.

The facility must have procedures for proper handwashing.

**This REQUIREMENT is not met as evidenced by:**

> Based on policy review, observations and interview, it was determined the facility failed to ensure Certified Nursing Assistants (CNA #1 and 2) and 3 of 16 nurses (Nurse #2, 3 and 15) observed washed their hands appropriately to prevent cross contamination.

The findings included:

1. Review of the facility’s "Handwashing/Hand Hygiene" policy documented, "...3.i. After contact with inanimate objects (e.g. [such as] medical equipment) in the immediate vicinity of the resident...5. Rinse hands with warm water... 7. Turn off faucet with paper towel..."
TENNESSEE STATE VETERANS HOME

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<tr>
<td>F 444</td>
<td>Continued From page 71</td>
<td>F 444</td>
<td>All Residents receiving finger stick blood glucose checks have the potential to be affected.</td>
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</table>

2. Observations of the West hall food tray delivery on 8/4/09 beginning at 7:40 AM, revealed CNA #2 brought a food tray to room 11D, touched the resident's personal items, used the bed electric device to raise the head of the bed, readjusted the resident's blanket, and brought the bedside table with the tray to the resident. CNA #2 then went to the linen room, brought out clean wash cloths, returned to the resident's room, wet a wash cloth and washed the resident's face and hands. CNA #2 then proceeded to the linen closet again to obtain clean wash cloths. CNA #2 then went to the middle hall, opened the food cart, touched the menu on a tray, touched another tray, then took out another tray to deliver. CNA #2 did not wash her hands at anytime during this observation.

3. Observations of the West hall food tray delivery on 8/4/09 beginning at 11:37 AM, revealed CNA #1 carried a food tray to room W08, placed the tray on the overbed table, moved the table, and walked out of the room to the food cart. CNA #1 moved clean trays around on the cart and removed another tray from the cart, took it to room W08 to the resident by the window and placed the tray on the overbed table. CNA #1 then returned to the cart, took out another tray and took the tray to room W09, moved the resident's water pitcher and overbed table, lowered the roommate's bedsprad and overbed table. CNA #1 did not wash her hands or sanitize them at anytime during these observations.

4. Observations of medication administration in room E03 on 8/3/09 at 3:40 PM, revealed Nurse #2 turned off the water with her wet hands then dried her hands with paper towel.
F 444  Continued From page 72

Observations of medication administration in room 3 on 8/4/09 at 4:15 PM, revealed Nurse #2 washed her hands, turned off the water with her wet hands, dried her hands with the paper towel and administered the medication. After administration of the medications Nurse #2 washed her hands, turned off the water with her wet hands, and dried her hands with the paper towel.

5. Observations of medication administration in room E28 on 8/3/09 at 4:10 PM, revealed Nurse #3 washed his hands, turned off the water with his wet hands and then dried his hands with a paper towel.

Observations of medication administration in room 25 on 8/4/09 at 4:05 PM, revealed Nurse #3 washed his hands, turned off the water with his wet hands and dried his hands with a paper towel.

6. Observations in Resident #36's room on 8/11/09 at 6:00 AM, revealed Nurse #15 did not wash her hands before or after doing an accucheck. Nurse #15 then proceeded to the next resident.

Observations in Resident #5's room on 8/11/09 at 6:10 AM, revealed Nurse #15 did not wash her hands before or after doing an accucheck. Nurse #15 then proceeded to the next resident.

Observations in Random Resident (RR) #1's room at 6:15 AM, revealed Nurse #15 did not wash her hands before doing an accucheck.

During an interview at the West hall nurses' station on 8/11/09 at 7:25 AM, Nurse #15 stated, there was a skills fair conducted by the facility Staff Development Masters prepared Registered Nurse and sister facility Certified Diabetic Educator on 08-11-09 for all Licensed Nurses with content that included Insulin Administration with return demonstration, Physician Notification, Professional Standards and facility policy for Insulin Administration and Blood Glucose Checks with return demonstration.

The facility Compliance Nurse, Quality Improvement Nurse and Staff Development Coordinator will also perform monthly medication pass reviews on alternating shifts for 3 months and then quarterly as part of an on-going Quality Improvement Plan. The results of the medication passes will be reported to the Quality Improvement Team for review.
Continued From page 73
"We are suppose to wash hands after each accuchek."

F 444

F 502

SS=D

The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review and interview, it was determined the facility failed to provide laboratory services in timely manner as ordered by the physician or obtain an order from the physician to perform a laboratory (lab) test for 2 of 46 (Residents #3 and 6) sampled residents.

The findings included:

1. Review of the facility's "Lab Processing Guidelines" documented, "Order for lab is obtained from physician and T.O. [telephone order] is written. If routine or scheduled lab order, fax copy of order to pharmacy. Complete lab request slip and place in lab folder. Contact [name of contracted lab] to request lab to be drawn..."

2. Medical record review for Resident #3 documented an admission date of 5/26/09 with diagnoses of Fractured Neck of Femur, Hypertension, Muscle Weakness, Alcoholic Dementia, Anemia and Pulmonary Congestion. Review of a physician's order dated 6/9/09 documented, "Lab on 8/9/09 VA [Valporic Acid] level. The facility was unable to provide documentation that the VA level was obtained as

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All Residents have the potential to be affected.

The Staff Development Nurse or designee educated all Licensed Nurses regarding proper handwashing techniques. The Certified Nursing Assistants are being educated and the education is on-going.

The facility Compliance Nurse will perform random handwashing checks weekly for 4 weeks and will report findings to the Quality Improvement Team for review. Infection Control education including hand washing is included in the facility orientation program. The infection control education is on-going through the TSVH University that is required yearly. The Staff Development Coordinator will tracks the education hours.
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<td>During an interview in the conference room on 8/4/09 at 2:05 PM, Nurse #12 stated, &quot;They cannot find the VA level on [Named Resident #3] for 6/9/09.&quot;</td>
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3. Medical record review for Resident #6 documented an admission date of 6/17/08, with diagnoses of Diabetes and Osteoarthritis. Review of a physician's order dated 6/1/09 documented "Request Hgb A1C delete (last one 3/16/09)." Review of a physician's order dated 7/8/09 documented, "HGB [hemoglobin] A1C Q every 3 MONTHS." Review of the lab reports for 6/11/09 and 7/6/09 documented a Hgb A1C had been obtained on Resident #6. The facility failed to ensure there was a physician's order for the Hgb A1C that was obtained on 7/6/09.

During an interview in the conference room on 8/5/09 at 5:40 PM, Nurse #13 stated, "Dietary requested it [Hgb A1C] when the insulin was dc'd [discontinued], but she marked it out. I don't know why."

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The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

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Continued From page 74

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483.75(l)(1) CLINICAL RECORDS

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

The medical record for Resident #3 regarding prescribed laboratory studies. The Physician was notified of any missing lab values. The Valproic Acid level was drawn on 07-02-09 with no further orders from the attending Physician.

The medical record for Resident #6 was reviewed regarding laboratory studies. The attending Physician was notified for any discrepancies found. All Residents have the potential to be affected.

The nurses were re-educated by 8-23-09 regarding twenty four hour chart checks and completing laboratory slips. The night Nurses will check each chart nightly for orders written for the past 24 hours. The Nurse will further ensure that the order has been transcribed and lab orders are carried out.

The Director of Nurses or designee(s) will audit laboratory orders to ensure that labs are being collected as prescribed. The audits will be completed monthly for 3 months and reported to the Quality Improvement Team for review.
TENNESSEE STATE VETERANS HOME

This REQUIREMENT is not met as evidenced by:
Based on medical record review, it was determined the facility failed to ensure physician's orders were accurately documented for a lap buddy or accuchecks for 2 of 48 (Resident #9 and #44) sampled residents.

The findings included:

1. Medical record review for Resident #9 documented an admission date of 4/18/09 with diagnoses of late effects Cerebral Vascular Accident, Depression, Malignant Neoplasm Prostate, Dementia, Hypertension, Atrial Fibrillation. Review of the physician's orders dated 7/8/09 documented, "...SAFETY /RESTRAINTS... LAP BUDDY WHEN UP IN W/C [wheelchair], POOR SAFETY WARENESS IN ABILITY TO STAND W/ [with] 2 PERSON ASSIST & [and] POOR... TRUNK CONTRO [control] CHECK & RELEASE FREQUENTLY FOR TOILETING AND EXERCISE..."

Observations in Resident #9's room on 8/3/09 at 1:05 PM, 3:25 PM and 4:24 PM, revealed Resident #9 seated in w/c with no lap buddy in place.

Observations in the resident lounge on 8/4/09 at 10:15 AM, revealed Resident #9 seated in a w/c with no lap buddy in place.

During an interview in Resident #9's room on 8/4/09 at 8:52 AM, Nurse #8 stated, "Resident can't get up alone, unassisted."
Continued from page 76

During an interview in the east wing on 8/5/09 at 10:05 AM, Nurse #6 stated, "Had order for one [lap buddy] ... tried one [lap buddy] ... he [Resident #9] could get out so went to self release belt."

2. Medical record review for Resident #44 documented an admission date of 4/22/09 with diagnoses of Hyperphosphatemia, and Infected AV Fistula. Review of a physician's order dated 5/21/09 documented, "D/C [discontinue] SSI [sliding scale insulin], D/C accucheck." The facility had no documentation that accuchek were obtained after 5/21/09. Physician's re-certification orders for 5/3/09 and 7/8/09 documented, "SSI per Protocol... Sliding Scale (REGULAR) <60, CALL MD [Medical Doctor], HOLD ANY SCHEDULED INSULIN UNTIL VERIFIED WITH MD 150-200 = [amount of insulin to be administered according to accucheck results] 2UNITS... 201-250 = 4 UNITS... 251-300 = 6 UNITS... 301-350 = 8 UNITS... 351-400 = 10 UNITS... > [greater than] 401 = 12 UNITS, RECHECK IN 2 HOURS AND IF STILL >401, CALL MD..."

During an interview in the conference room on 8/10/09 at 4:30 PM, the Corporate Compliance Nurse verified that Resident #44 orders for 6/3/09 and 7/8/09 were clerical errors and should not have been carried over.

The medical record for Resident #9 was reviewed and the orders were clarified.

The medical record for Resident #44 has been reviewed and the orders were clarified.

All Residents have the potential to be affected.

The Licensed Nurses were educated regarding order transcription and monthly order checks.

The Pharmacy Nurse and designee(s) will continue to check the monthly orders for accuracy. The night shift Nurses will perform a "double check" to ensure orders are accurate before placing on the medical record.

The night shift nurses will also be responsible for completing 24 hour chart checks daily for orders written in the past 24 hours.

The Director of Nurses or designee(s) will randomly audit at least 25% of the monthly orders monthly for 3 months for accuracy. The audits will be reported to the Quality Improvement Team for review.