**NAME OF PROVIDER OR SUPPLIER**

**THE KINGS DAUGHTERS AND SONS**

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

3658 APPLING ROAD
BARTLETT, TN 38133

**DATE SURVEY COMPLETED**

03/14/2012

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 164 SS=0</td>
<td>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</td>
<td>F 164</td>
<td>The King's Daughters and Sons Home shall ensure the personal privacy and confidentiality of each resident's personal and clinical records.</td>
<td>3/15/2012</td>
</tr>
<tr>
<td></td>
<td>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</td>
<td></td>
<td>Both nurses who left the MAR open and unattended on the medication cart on 2 North were instructed by the Director of Nursing Service on the proper procedure of closing the MAR when they step away from the medication cart on March 15, 2012.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
<td>All nurses received refresher training on privacy and confidentiality of resident records and personal information on March 20, 2012 by the Director of Nursing Service. Proper procedure of closing MARs when away from the medication cart was included.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</td>
<td></td>
<td>The Director and Assistant Director of Nursing Service shall observe nurses passing medications on the floors during their daily rounds to ensure that nurses are closing the MAR when away from the medication cart. Any improper procedures shall be corrected immediately.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</td>
<td></td>
<td>(F 164 continued on next page)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility staff failed to maintain privacy and confidentiality of the residents' medical records by leaving the Medication Administration Record (MAR)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Signature**

**DATE**

3/16/2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
F 164: Continued From page 1

uncovered with residents information visible on 2
of 3 (3/13/12 and 3/14/12) days of the state
survey.

The findings included:

1. Review of the facility's "Medication
Administration General Guidelines" documented,
"...Resident's health information needs to remain
private. The pages of the MAR notebook
containing resident health information must
remain closed or covered when not in direct
use..."

2. Observations on the North 2 hall on 3/13/12 at
7:49 AM, revealed Nurse #5 left the MAR open
and unattended with a resident's information
visible.

During an interview on the North 2 hall on 3/13/12
at 8:07 AM, Nurse #5 was asked, "What do you
do with the MAR when entering a room?" Nurse
#5 stated, "...usually close it..."

3. Observations on the North 2 hall on 3/14/12 at
9:12 AM, revealed Nurse #1 left the MAR open
and unattended with a resident's information
visible.

4. During an interview in the Director of Nursing's
(DON) office on 3/14/12 at 9:48 AM, the DON
was asked, "What do you expect the nurses to do
with the MAR when they leave the cart?" The
DON stated, "...it [MAR] should be closed..."

F 221: (F 221 started on next page)

483.13(a) RIGHT TO BE FREE FROM
PHYSICAL RERAINTS
The resident has the right to be free from any
**THE KINGS DAUGHTERS AND SONS**

<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>
</tr>
</thead>
<tbody>
<tr>
<td>F 221</td>
<td>Continued From page 2</td>
<td></td>
<td>physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Based on policy review, medical record review, observation, and interview, it was determined the facility failed to ensure a pre-restraint assessment, an informed consent, or a restraint reduction assessment for a physical restraint was completed for 2 of 4 (Residents #4 and 8) sampled residents with physical restraints.

The findings included:

1. Review of the facility's physical restraint policy documented, "...Assess resident's need for restraint use... Obtain informed consent for restraint use... Restrainted individuals should be reviewed AT LEAST QUARTERLY to determine whether or not they are candidates for restraint reduction, less restrictive restraining measures, or total restraint elimination..."

2. Medical record review for Resident #4 documented an admission date of 7/1/07 with diagnoses of Dementia, Congestive Heart Failure, Hypertension and Peripheral Vascular Disease. Review of a physician's order dated 1/15/10 documented, "...lap buddy when up in wheelchair..." Review of the restraint reduction assessments revealed no assessments documented after 8/11/11.

Observations in Resident #4's room on 3/12/12 at 10:00 AM, and on 3/13/12 at 7:40 AM and 9:00...
Continued From page 3

AM, revealed Resident #4 seated in a wheelchair with a lap buddy in place.

During an interview at the South 2 nurses' station on 3/13/12 at 11:15 AM, the Assistant Director of Nursing (ADON) was asked to locate the restraint reduction assessments after 8/11/11. The ADON stated, "...we do not have the assessments for November [2011] or February [2012]."

3. Medical record review for Resident #8 documented an admission date of 7/12/07 with diagnoses of Muscle Weakness-General, Convulsions, Craniotomy, Ataxia, Intracerebral Hemorrhage, Abnormal Posture and Headache. Review of the physician's order dated 1/16/12 documented, "...Up IN W/C [wheelchair] DAILY WITH SOFT BELT RESTRAINT FOR POSITIONING, CHECK EVERY 30 MIN [minutes] & [and] RELEASE EVERY 2 HOURS FOR RE-POSITIONING..." There was no documentation of a pre-restraint assessment or an informed consent for the application of the soft belt restraint in use for Resident #8.

Observations in Resident #8's room on 3/12/12 at 2:25 PM, revealed Resident #8 seated in a w/c wearing a soft belt restraint.

During an interview in the conference room on 3/13/12 at 2:55 PM, the Director Of Nursing (DON) was asked about a pre-restraint assessment and an informed consent for the soft belt restraint for Resident #8. The DON confirmed she was unable to find a pre-assessment or an informed consent for the use of the soft belt restraint.

(F 221 Continued)

Restraint reduction assessments will be conducted quarterly. Pre-restricting assessments will be completed for all new restraint orders. Informed consents will be obtained on all new restraint orders.

The Continued Quality Improvement Coordinator (ADON) shall conduct monthly Quality Assurance audits of medical records of restrained residents to ensure that required pre-restraint assessments and restraint reduction assessments are performed and these documents are maintained in the medical record. The CQI Coordinator shall also audit medical records of restrained residents to ensure that the informed consent form is maintained in the record. These audits will be quarterly and reported to the Quality Assurance Committee.
**F 253** Continued From page 4

**SS=D MAINTENANCE SERVICES**

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

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

Based on observation and interview, it was determined the facility failed to keep resident care equipment properly stored in shared bathrooms for 10 of 13 (rooms 201 and & 203, 202 & 204, 205 & 207, 209 & 211, 210 & 212, 213 & 215, 217 & 219, 218 & 220, 221 & 223, and 222 & 224) bathrooms observed on the North 1 hall.

The findings included:

Observations of the North 1 hall bathrooms on 3/12/12 beginning at 9:20 AM and on 3/13/12 beginning at 9:25 AM revealed the following:

a. room 201 & 203 - 2 toothbrushes in a wash basin not covered or labeled, a bed pan hung on the safety handrail beside the toilet not covered and unlabeled, a hairbrush and comb on the vanity not labeled.

b. room 202 & 204 - 2 emesis basins not covered and unlabeled each containing a toothbrush.

c. room 205 & 207 - an opened bar of soap and 2 toothbrushes in a bath basin on top of the vanity not covered and unlabeled, an open bar of soap and toothbrush in a plastic cup on the vanity not covered and unlabeled, a hairbrush and a comb on the vanity not covered and unlabeled, a bedside commode hat on the floor not covered and unlabeled.

d. room 209 & 211 - 2 urinals on the safety
F 253: Continued From page 5
handrail beside commode not covered and unlabeled, an open bar of soap on a paper towel on top of the vanity not covered and unlabeled. e. room 210 & 212 - 1 wash basin on top of a trash can and 1 pair of latex gloves on the floor behind the trash can, 2 unlabeled toothbrush holders, and 1 open bar of soap on the vanity. f. room 213 & 215 - a plastic drinking cup on a box beside the commode unlabeled and a hairbrush on the vanity not covered and unlabeled. g. room 217 & 219 - 3 emesis basins stacked together on the vanity containing 2 toothbrushes and an open bar of soap not covered and unlabeled, a bedpan on the safety handrail beside the commode not covered and unlabeled. h. room 216 & 220 - 2 emesis basins not covered and unlabeled each containing a toothbrush. i. room 221 & 223 - 2 toothbrushes, a comb and hairbrush in a plastic cup on the vanity not covered and unlabeled. j. room 222 & 224 - 2 emesis basins and 2 toothbrush holders containing toothbrushes not covered and unlabeled on the vanity.

During an interview in room 201 on 3/13/12 at 9:25 AM, Nurse #2 was asked about the unlabeled and uncovered items in the shared bathrooms. Nurse #2 stated, "I don't know, there is usually a name on them [residents' personal care equipment]. They [items] are supposed to have names on them."

F 280: 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP
The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to

(F 280 started on next page)
Continued From page 6

participate in planning care and treatment or changes in care and treatment.

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

This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review, observation and interview, it was determined the facility failed to revise the current care plan for medications, oral care, Prostat, self feeding and heel protectors for 1 of 21 (Resident #5) sampled residents.

The findings included:

Review of the facility's "RESIDENT CARE PLAN" policy documented, "...APPROACH/PLAN A. List all care to be provided for the problem listed. The care must be NECESSARY AND APPROPRIATE to accomplish the goal stated... c. Individualize care for the unique needs of the resident... RE-EVAL [re-evaluate]... B. The care plan must be reviewed and revised (updated) as

The King's Daughters and Sons Home shall ensure that a comprehensive care plan is developed for each resident and, to the extent practicable, include the participation of the resident, the resident's family or the resident's legal representative. The care plan shall be periodically reviewed and revised by a team of qualified professionals as needed to reflect the resident's current condition.

The Care Plan for Resident #5 was reviewed and revised to reflect the resident’s current medical status as reflected in the medical record and current physician orders.

Resident #5 was evaluated and no negative outcome was sustained from his outdated Plan of Care.

A good system was in place to ensure that the Care Plan Coordinators have up to date orders in order to revise Care Plans. The Care Plan Coordinator simply did not revise this Plan of Care. This individual is no longer employed at this facility.

(F 280 continued on next page)
Continued From page 7
necessary... RESIDENT CARE PLAN
DOCUMENTATION AND USE OF THE PLAN...
B. The licensed nurses must review the resident
care plan each time an order is received from a
physician to determine if an entry is needed...

Medical record review for Resident #5
documented an admission date of 10/1/99 with
diagnoses of Benign Hypertension, Vascular
Dementia, Cerebrovascular Accident and
Peripheral Arterial Disease. Review of a
physician's order dated 1/30/12 documented,
"...D/C [discontinue] prostat 64 bid [twice a
day],..." Review of the physician's orders dated
2/13/12 documented, "...DILANTIN 50 MG
[milligram] INFATAB... 6 TABS [tablets] (300MG)
ORALLY AT BEDTIME... MAPAP [Tylenol] 325
MG TABLET... 2 TABLETS (650 MG) ORALLY
EVERY 4 HOURS AS NEEDED FOR PAIN,..." Review of a
physician's order dated 3/9/12
documented, "...Heel protectors,..."

Review of the care plan dated 5/4/10 and updated
January 2012 documented the following
interventions:
a. ". . . Potential for seizures... 8/18/10... dilantin
50mg infatabs (5 tabs) po [orally] q [every] hs
[bedtime]. . ."
b. ". . . Resident is edentulous. He can perform OH
[oral hygiene] per self with setup... Provide setup
for OH Q [every] am, allow him to perform per
self,..."
c. ". . . Give scheduled pain meds to decrease pain
with mobility (per orders). Tylenol 650 mg bid...
d. ". . . Resident is at a nutritional risk... Prostat 64
po per MD [Medical Doctor] orders... Provide tray
setup and observe for self feeding q meal daily,
assist him when he becomes tired or is unable to

(F 280 Continued)
The Director of Nursing Service shall
cause a Quality Assurance Audit
(Continuous Quality Improvement (CQI)) to be conducted on all care plans
to ensure that care plans properly reflect
the medical condition of each resident and
current medical orders for the resident. Any omissions found will be
researched and corrected immediately.

The Continuous Quality Improvement Nurse (ADON) shall conduct monthly
Quality Assurance (CQI) audits of care plans to ensure that the care plan
reflects the current condition and
medical orders for each resident.
Results of these audits will be reported
to the Quality Assurance Committee
quarterly. The frequency and duration of further audits will be determined by
the committee.
**NAME OF PROVIDER OR SUPPLIER**

**THE KINGS DAUGHTERS AND SONS**

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

3568 APPLING ROAD

BARTLETT, TN 38133

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(EACH DEFICIENCY MUST BE PRECEDED BY FULL</td>
</tr>
<tr>
<td></td>
<td>REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(EACH CORRECTIVE ACTION SHOULD BE</td>
</tr>
<tr>
<td></td>
<td>CROSS-REFERENCED TO THE APPROPRIATE</td>
</tr>
<tr>
<td></td>
<td>DEFICIENCY)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/14/2012</td>
</tr>
</tbody>
</table>

---

**F 280** Continued From page 8

complete meal without spilling...

The care plan documented no interventions for the heel protectors.

Observations in Resident #5's room on 3/12/12 at 10:08 AM, 2:45 PM, 5:00 PM and 6:00 PM and on 3/13/12 at 7:50 AM, 8:15 AM and 9:55 AM, revealed Resident #5 in bed wearing bilateral heel protectors.

Observations in Resident #5's room on 3/12/12 at 6:00 PM and 3/13/12 at 7:50 AM, revealed Resident #5 was being fed by a Certified Nursing Assistant (CNA).

During an interview at the South 2 hall nurses' station on 3/14/12 at 9:40 AM, CNA #6 was asked if Resident #5 ever attempted to feed himself. CNA #6 stated, "...No, we totally feed him... doesn't try because his hands are shaky..." CNA #6 was asked if they ever set up Resident #5 for oral care and let him perform his own oral hygiene. CNA #6 stated, "...No, he won't let us put dentures in... we swab his mouth with lemon swabs..."

During an interview in the conference room on 3/14/12 at 9:55 AM, Nurse #3 was asked if the Dilantin, Tylenol, oral care, Prostat and self feeding were accurate. Nurse #3 stated, "...No..." Nurse #3 was asked if the heel protectors were on the care plan. Nurse #3 stated, "...I didn't see it..."

**F 309** 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain...
F 309: Continued From page 9

or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:

Based on policy review, medical record review and interview, it was determined the facility failed to follow physician's orders for notification of blood glucose levels above 400 or failed to administer medications when a resident failed to have a bowel movement for 8 of 21 (Resident #6, 10, 11, 12, 15 and 17) sampled residents.

The findings included:

1. Review of "FACILITY STANDING PROTOCOL" dated 12/8/12 documented, ". . . for fingerstick blood glucose levels of . . . over 400: [gave] 12 units [Humulin R or Novolin R Insulin] and notify MD [Medical Director] . . . ."


3. Medical record review for Resident #8 documented an admission date of 12/8/11 with diagnoses of Congestive Heart Failure.

F 309: (F 309 started from previous page)

The King's Daughters and Sons Home shall ensure that each resident receives 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 shall include ensuring physician standing orders are followed as written.

Standing orders for blood sugar levels above 400 will be followed. Nurses will contact the physician and will document that they have contacted the physician on all residents who have blood sugar levels above 400.

All nurses received in-service education on March 20, 2012 on proper procedures in following standing orders regarding blood sugar levels above 400 and documenting notification of the physician.

(F 309 continued on next page)
F 309 Continued From page 10

Pulmonary Fibrosis, Hypertension, Diabetes Mellitus and Osteoarthritis. Review of Resident #6's Medication Administration Record (MAR) dated 12/30/11 documented a blood glucose level of 410 with no documentation of physician notification. Review of the MAR dated 1/2/12 documented a blood glucose level of 414 with no documentation of physician notification. Review of the MAR dated 1/4/12 documented a blood glucose level of 434 with no documentation of physician notification. Review of the MAR dated 1/16/12 documented a blood glucose level of 487 with no documentation of physician notification. Review of the MAR dated 1/29/12 documented a blood glucose level of 406 with no documentation of physician notification.

During an interview in the South 2 hall on 3/14/12 at 9:35 AM, Nurse #4 was asked about the procedure for blood glucose levels of greater than 40. Nurse #4 stated, "...give 12 units... call the doctor... document on the nurses' notes..." Nurse #4 was asked if there was any other location to chart physician notification. Nurse #4 stated, "No."

During an interview in the conference room on 3/14/12 at 1:45 PM, the Director of Nursing (DON) confirmed there was no documentation of physician notification of the elevate blood glucose level.

4. Medical record review for Resident #10 documented an admission date of 2/23/06 with diagnoses of Intracerebral Hemorrhage due to Head Injury, Dementia, Dysphagia and Movement Disorder. Review of Resident #10's "Resident Care Flow Record" documented no BM for the

F 309 (F 309 Continued)

Standing orders for constipation will be followed. Residents experiencing no bowel movement for three days will receive MOM or Bisacodyl Suppository as directed in the standing order. Administration of MOM or Bisacodyl Suppositories will be documented in the MAR.

CNA's will document bowel movements as they occur for each resident on the ADL sheet.

Staff nurses received in-service instruction on following Standing Orders for Constipation and proper documentation of medication administration per standing orders.

CNA's will receive in-service instruction on properly documenting BM's on the ADL sheet on March 29, 2012.

The Director of Nursing Service shall cause monthly reviews of ADL sheets to determine that proper documentation is carried out. Corrective action will be taken to ensure that staff are properly documenting events that should be documented.

(F 309 continued on next page)
<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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F 309 (Continued) From page 11 following dates: 12/7/11 through (-) 12/10/11; 12/12/11 - 12/16/11; 1/2/12 - 1/5/12; 1/9/12 - 1/13/12; 1/15/12 - 1/21/12; 1/31/12 - 2/4/12 and 3/6/12 - 3/12/12. Review of Resident #10's &quot;Care Plan&quot; updated 11/3/11 documented, &quot;...Potential for constipation... If no BM in 3 days, use MD standing orders for constipation...&quot; Review of Resident #10's MAR dated December 2011, January, February and March 2012 contained no documentation of MOM or Bisacodyl Suppository being administered as per protocol and physician orders. During an interview in the North 1 nurses' station on 3/13/12 at 9:40 AM, the Assistant Director of Nursing (ADON) was asked to review Resident #10's December 2011, January 2012, February 2012 and March 2012 documentation concerning BMs. The ADON confirmed there were no BM or interventions documented and stated, &quot;...If no BM 48 hours they [nurses] are to implement the physician's constipation standing orders... Nurses are to monitor the BM status and intervene on the third day if no BM...&quot; 5. Medical record review for Resident #11 documented an admission date of 3/2/07 with diagnoses of Diabetes Mellitus, Benign Hypertension, Pleural Effusion, Depression, Psychosis, Coronary Artery Disease, and Generalized Muscle Weakness. Review of the physician orders dated 12/28/11 documented, &quot;...NOVOLIN R [Regular] 100 UNITS/ [per] ML [milliliter] VIAL (INSULIN REGULAR, HUMAN) SLIDING SCALE SQ [subcutaneously] ... [greater than] 400=12 UNITS &amp; [and] NOTIFY MD...&quot; Review of Resident #11's January 2012 MAR documented blood sugar levels on 1/2/12 at</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
F 309 Continued From page 12

6:00 AM - 495 milligrams per deciliter (mg/dl) and on 1/16/12 at 4:00 PM - 448 mg/dl. Review of Resident #11's February 2012 MAR documented blood sugar levels on 2/7/12 at 4:00 PM - 438 mg/dl, on 2/13/12 at 4:00 PM - 412 mg/dl, on 2/14/12 at 4:00 PM - 488 mg/dl, on 2/17/12 at 4:00 PM - 409 mg/dl, on 2/24/12 at 4:00 PM - 413 mg/dl, on 2/27/12 at 4:00 PM - 407 mg/dl and 2/29/12 at 4:00 PM - 455 mg/dl. Review of Resident #11's March 2012 MAR documented blood sugar levels on 3/7/12 at 4:00 PM - 478 mg/dl and on 3/8/12 at 4:00 PM - 414 mg/dl. The facility was unable to provide documentation that the MD was notified of blood sugar levels greater than 400.

During an interview on the North 1 hall on 3/14/12 at 8:12 AM, Nurse #1 was asked where documentation of MD notification of blood sugar levels greater than 400 would be found. Nurse #1 stated, "It would be in the nurse's notes or on the back of the MAR."

During an interview in the conference room on 3/14/12 at 11:30 AM, the ADON stated, "There is no documentation of MD notification for blood sugar levels greater than 400."

6. Medical record review for Resident #12 documented an admission date of 9/24/91 with diagnoses of Quadriplegia, Asthma, Neurogenic Bladder, Hypertension and Decubitus Ulcer. Review of the care plan updated 11/8/11 documented, "...Potential for constipation... If no BM in 3 days, use MD standing orders for constipation..." Review of the physician's order dated 1/1/12 through 1/31/12 documented, "...Milk of Magnesia Suspension Give 30ML."
F 309 Continued From page 13

[medication] Orally Daily As Needed For Constipation..." Review of Resident #12's "Resident Care Flow Record" had no BM documented from 1/17/12 - 1/21/12. Review of Resident #12's January 2012 MAR contained no documentation of MOM or Bisacodyl Suppository being administered.

During an interview in the North 1 nurses' station on 3/13/12 at 9:40 AM, the ADON was asked to review Resident #12's medical record concerning bowel movements (BM) and interventions for lack of BM. The ADON confirmed Resident #12 had no BM or interventions documented from 1/17/12 - 1/21/12. The ADON stated, "...If no BM 48 hours they [nurses] are to implement the physician's constipation standing orders...Nurses are to monitor the BM status and intervene on the third day if no BM."


8. Medical record review for Resident #17 documented an admission date of 2/25/85 with diagnoses of Esophageal Reflux, Atony of the
F 309 Continued From page 14

Bladder, Schizoaffective and Diabetes Mellitus Type II. Review of the "RESIDENT CARE FLOW RECORD" for February and March 2012 had no BM documented on the following dates: 2/4/12 - 2/9/12; 2/10/12 - 2/12/12; 2/14/12 - 2/16/12 and 3/4/12 - 3/6/12. Review of the February and March 2012 MARs had no documentation that MOM or Bisacodyl were administered on any date.

During an interview at the South 2 hall nurses’ station on 3/14/12 at 1:30 PM, Nurse #4 was asked if any prn laxative had been given for the no BM in 3 days. Nurse #4 stated, "...You're right, it’s [laxative] not anywhere on here [MAR]..." Nurse #4 was asked if a laxative should have been given. Nurse #4 stated, "Yes [if no BM in 3 days]."

F 315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER

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 medical record review, observation and interview, it was determined the facility failed to provide valid medical justification for the use of

The King’s Daughters and Sons Home shall ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident’s clinical condition demonstrates that catheterization is 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.

The catheter for Resident #1 was incorrectly retained following an attempt to obtain a urine sample per physician order on 2/19/2012.

(F 315 continued on next page)
**F 315** Continued From page 15

an indwelling catheter for 1 of 6 (Resident #1) sampled residents with a catheter.

The findings included:

Medical record review for Resident #1 documented an admission date of 11/18/11 with diagnoses of Hypotension, Dehydration, Urinary Tract Infection, Hypertension, Cerebrovascular Accident, End Stage Parkinson's and Dementia.

Review of a physician's order dated 2/19/12 documented, "...UA [urinalysis] C+S [culture and sensitivity] now for pick up stat by lab... Foley catheter insertion to drain bag change per protocol..." Review of the nurse's notes dated 2/19/12 documented, "...Nurse unable to obtain enough urine by in and out cath [catheter]... Foley catheter insertion to drain bag... about 50 cc [cubic centimeters] of dark amber urine noted in foley bag, UA, C+S obtained..."

Observations in Resident #1's room on 3/12/12 at 9:32 AM, 2:15 PM and 5:00 PM, on 3/13/12 at 8:15 AM and 11:00 AM and on 3/14/12 at 7:45 AM, revealed Resident #1 with an indwelling catheter.

During an interview in the Director of Nursing's (DON) office on 3/13/12 at 9:37 AM, the Director of Nursing (DON) was asked, "Why does [named Resident #1] have a catheter?" The DON stated, "...she had a rash...there were no open areas..."

**F 323** 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives

(F 315 Continued)

Immediate corrective action was taken on 03/16/2012 by removing the catheter. A new order has been written regarding the use of a catheter for this resident should the resident experience urinary retention.

The Director of Nursing Service shall conduct a review of all residents with indwelling catheters to determine that there is valid medical justification for the use of an indwelling catheter and that there is a valid order for such catheter.

The Continuous Quality Improvement Coordinator shall conduct quarterly CQI audits of catheter usage to ensure that residents with indwelling catheters have valid medical justification for the use of an indwelling catheter and that there is a valid order for such catheter. This shall be done for two quarters. Results of these audits will be reported to the Quality Assurance Committee quarterly. The frequency and duration of further audits will be determined by the committee.

(F 323 started on next page)
**F 323** Continued From page 16

adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review, observation and interview, it was determined the facility failed to follow interventions put in place to prevent falls, failed to update the care plan with interventions for falls and failed to complete a fall risk assessment for 4 of 7 (Residents #13, 15, 16 and 18) sampled residents with falls.

The findings included:

1. Review of the facility's "Fall Policy" documented, "...B. Documentation and Follow-up... 3. Refer to the interdisciplinary treatment team to review fall preventions and modify care-plan as appropriate..."

2. Medical record review for Resident #13 documented an admission date of 7/8/11 with diagnoses of Cerebrovascular Accident (CVA), Dysphasia, Speech Disturbance, Hemiparesis Dominant Side, Epilepsy and Gastrostomy. Resident #13's nurses' notes documented falls with no injuries on 7/8/11 (6:50 AM and 11:00 AM), 8/15/11, 8/27/11, 8/29/11, 9/2/11, 9/8/11, 10/13/11, 11/4/11, 12/7/11, 12/12/11, 1/15/12, 1/16/12 and 2/17/12. Review of the care plan dated 7/21/11 and updated on 3/1/12 documented no new interventions for falls on the following dates: 12/7/11, 1/15/12 and 3/1/12. The care plan documented, "...no new fall

**F 323** (F 323 started from the previous page)

The King’s Daughters and Sons Home shall ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

Residents #13, 15, 16 and 18 will be re-assessed for falls and new interventions have been put in place for each of these residents. All plans of care have been updated to ensure consistency with the resident’s specific conditions, risks, needs, behaviors, and preferences. Staff providing care for these residents have received instruction from the Assistant Director of Nursing Service to ensure that interventions identified in the plan of care are being followed.

All fall risk assessments shall be reviewed for current residents to ensure that assessments are current, care plans are up to date and that interventions are in place.

A fall risk assessment will be completed upon admission and quarterly throughout each resident stay at the facility.

(F 323 continued on next page)
**THE KINGS DAUGHTERS AND SONS**

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 323</td>
<td>Continued From page 17 interventions...&quot; regarding the fall which occurred on 2/17/12.</td>
</tr>
<tr>
<td></td>
<td>Review of the facility's &quot;Unusual Occurrence Report Forms&quot; for Resident #13 documented a fall on 3/1/12 that was not documented in the nurses' notes.</td>
</tr>
</tbody>
</table>
|         | During an interview in the conference room on 3/14/12 at 7:46 AM, the Assistant Director of Nursing (ADON) was asked if any interventions were documented on the care plan for the 12/7/11, 1/15/12, 2/17/12 or 3/1/12 falls. The ADON stated, "I don't see 12/7/11 [fall interventions] on care plan... no new interventions on care plan [regarding falls on 1/15/12, 2/17/12 and 3/1/12]."


---

<table>
<thead>
<tr>
<th>(F 323 Continued)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed and chair alarms have been ordered to be used as an intervention for residents deemed appropriate for such alarms.</td>
<td>3/20/2012</td>
</tr>
<tr>
<td>The falls committee will meet to review each fall in order to determine the cause of the fall. New or revised interventions will be put in place for each resident experiencing a fall to prevent additional falls. All revisions will be updated on the resident's plan of care and reviewed with the staff providing care for the resident.</td>
<td>3/23/2012</td>
</tr>
<tr>
<td>All staff will be in serviced on our Falls Policy, which includes ensuring compliance of fall and fall-related injury interventions and proper documentation.</td>
<td>3/29/2012</td>
</tr>
<tr>
<td>The CQI Nurse will audit care plans of residents with falls and potential for falls quarterly to determine if falls risk assessments have been completed, new interventions have been developed, orders are being followed and the plan of care is updated and being implemented. The results of these audits will be reported to the CQI Committee.</td>
<td></td>
</tr>
</tbody>
</table>
F 323 Continued From page 18

Observations at the South 2 hall neighborhood on 3/12/12 at 2:00 PM, revealed Resident #15 seated in a reclined gerichair in the process of sliding down in the chair.

Observations at the South 2 hall neighborhood on 3/13/12 at 4:30 PM, revealed Resident #15 seated in a reclined gerichair.

During an interview in the conference room on 3/14/12 at 10:54 AM, the Director of Nursing (DON) and Nurse #3 confirmed there were no new interventions documented in the nurses' notes or on the care plan after the falls on 3/7/11, 3/20/11, 5/14/11, 6/10/11, 6/20/11, 7/11/11, 11/27/11 and 12/18/11.

4. Medical record review for Resident #16 documented an admission date of 10/28/11 with diagnoses of Hypertension, Esophageal Reflux, Urinary Tract Infection and Depressive Disorder. Review of the initial Minimum Data Set (MDS) dated 11/9/11 documented, "...Section C Cognitive Patterns... C0500. Summary Score 05..." Review of the quarterly MDS dated 2/1/12 documented, "...Section C Cognitive Patterns... C0500. Summary Score 06..." indicating Resident #16 is cognitively impaired. Resident #16's nurses' notes documented falls with no injuries on 12/18/11, 12/20/11, 12/30/11, 1/16/12, 1/19/12, 1/20/12, 1/27/12, 2/1/12 and 2/21/12.

Review of Resident #16's care plan dated 10/28/11 documented, "...Potential for additional falls r/t [related to] hx [history] of falls prior to admission... Give verbal reminders not to ambulate or transfer without assistance... Ensure that patient has and wears properly-fitting
F 323 Continued From page 19
non-skid soled shoes for ambulation... make
rounds at least q [every] 2 hrs [hours]/prn [as
needed] & [and] more frequently as needed..." the
care plan also documented falls and interventions
as followed:
a. Falls 12/18/11 and 12/30/11 - "...Give verbal
reminders not to ambulate or transfer without
assistance..."
b. Fall 1/16/12 - "...Ensure that resident has and
wears properly-fitting non-skid soled shoes for
ambulation."
c. Falls 12/20/11, 12/30/11, 1/19/12, 1/20/12,
2/1/12 and 2/21/12 - "...make rounds at least q 2
hrs/prn & more frequently as needed..."
The facility failed to put new interventions in place
for the falls on 12/18/11, 12/20/11, 12/30/11,
1/19/12, 1/20/12, 2/1/12 and 2/21/12 and was
unable to provide documentation that any fall risk
assessments had been done.

During an interview in the conference room on
3/14/12 at 10:05 AM, the care plan dated
10/28/12 was reviewed with the DON and Nurse
#3. The DON and Nurse #3 were asked if there
were new interventions put in place for the falls
on 12/18/11, 12/20/11, 12/30/11, 1/19/12,
1/20/12, 2/1/12 and 2/21/12. Nurse #3 stated,
"...No..."

During an interview in the waiting room on
3/14/12 at 3:55 PM, the Administrator was asked
if the Fall Risk Assessments had been located.
The Administrator stated, "...No, we haven't..."

5. Medical record review for Resident #18
documented an admission date of 9/3/11 with a
readmission date of 6/27/11 with diagnoses of
Alzheimer's Dementia, Hypertension, Diabetes
F 323 Continued From page 20
Mellitus, Depression and Degenerative Disc Disease. Review of Resident #18's nurses' notes documented falls with no injuries on 12/28/11 and 1/17/12. Review of the care plan for falls updated on 1/22/12 documented no new interventions for the falls after the falls on 12/28/11 and 1/17/12.

During an interview in the DON's office on 3/14/12 at 9:55 AM, the DON confirmed there were no new interventions documented for Resident #18's falls on 12/28/11 and 1/17/12.

F 325 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE

Based on a resident's comprehensive assessment, the facility must ensure that a resident -
(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and
(2) Receives a therapeutic diet when there is a nutritional problem.

This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review and interview, it was determined the facility failed to implement new interventions for weight loss for 2 of 6 (Residents #6 and 16) sampled residents with weight loss.

The findings included:
1. Review of the facility's "WEIGHT POLICY &
<table>
<thead>
<tr>
<th>Provider Identification Number: 445221</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Provider or Supplier: The Kings Daughters and Sons</td>
</tr>
<tr>
<td>Street Address, City, State, Zip Code: 3599 Applling Road, Bartlett, TN 38133</td>
</tr>
<tr>
<td>Date Survey Completed: 03/14/2012</td>
</tr>
</tbody>
</table>

**Summary Statement of Deficiencies**

<table>
<thead>
<tr>
<th>F 325 Continued From page 21</th>
</tr>
</thead>
</table>

[and PROCEDURE" documented, "...The Registered Dietitian (RD) assesses each resident with a significant weight change, makes appropriate recommendations to physicians and updates the resident's plan of care."

2. Medical record review for Resident #6 documented an admission date of 12/8/11 with diagnoses of Congestive Heart Failure, Pulmonary Fibrosis, Hypertension, Diabetes Mellitus and Osteoarthritis. Review of Resident #6's weight sheet documented the following weights: an admission weight of 99.8 pounds (lb) on 12/9/11; 12/13/11 - 101.4 lbs; 12/20/11 - 97.1 lbs; 12/27/11 - 109.7 lbs; 1/2/12 - 108.8 lbs and 2/2/12 - 94.2 lbs.

The loss of 14.6 lbs in one month resulted in a significant weight loss of 13.4 percent (%). The weight record also documented a 3/5/12 weight of 88.6 lbs. The loss of 5.6 lbs in one month resulted in a significant weight loss of 5.9%.

Review of Resident #6's nutritional progress notes had no assessments documented for February or March 2012 after the significant weight losses were documented. The care plan dated 12/28/11 had new interventions put in place February and March 2012 after the significant weight losses were documented. Review of the previous care plan interventions documented, "...Offer substitute if < [symbol for less than] 50% of any meal consumed daily/prn [as needed],... Notify MD [Medical Doctor] of wt [weight] changes > [symbol for greater than] 5#'s [symbol for pounds] in one month...".

Resident #6's nurses' notes had no referrals made to the MD or to the RD for the documented

<table>
<thead>
<tr>
<th>F 325 (Continued)</th>
</tr>
</thead>
</table>

Each resident's weight will be monitored consistently and closely by the weight team. The weight team will meet monthly to review any resident with a significant weight change of 5% weight gain or loss in the prior 30, 60 and 90 day period, and all residents with wounds and/or who receive tube feedings. A communication book has been established for the Registered Dietician and will be kept on every wing of the facility.

The Registered Dietitian and Charge Nurse will be notified of residents with a significant weight change via the communication book. A significant weight change is indicated by a 3 pound weight gain or loss in 14 days. The Registered Dietitian will assess each resident with a significant weight change, makes appropriate recommendations to the physician and update the resident's plan of care. The Registered Dietician will assess each resident within 48 hours of admission and on a quarterly basis.

(F 325 continued on next page)
F 325 Continued From page 22

weight loss.

Review of Resident #6's resident care flow records for December 2011, January 2012 and February 2012 documented consistent meal intakes of 50% or less. The nurses' notes had no documentation of food substitutes being offered.

During an interview in the conference room on 3/14/12 at 2:05 PM, the Director of Nursing (DON) was asked to locate documentation of assessments, notification, and interventions regarding significant weight loss. The DON confirmed, "...it's not there..." The RD was asked if there was a weight management program in place. The RD stated, "...we are working on it..."

3. Medical record review for Resident #18 documented an admission date of 10/28/11 with diagnoses of Hypertension, Esophageal Reflux, Urinary Tract Infection and Depressive Disorder. Review of Resident #18's weight sheets documented the following weights:
   a. "...Nov [November] 114.4... 11/2/11.
   b. "...Dec [December] 108.6... 12/6/11.
   The loss of 5.8 pounds in one month resulted in a significant weight loss of 5.06%.

Review of Resident #18's quarterly dietary progress notes had no dietary assessment or notes documented regarding the significant weight loss of 5.06%. The facility was unable to provide any documentation of dietary interventions.

During an interview in the conference room on 3/14/12 at 1:50 PM, the RD was asked if any interventions had been put in place to address

(F 325 Continued)

Licensed nursing staff received in-service training by the Director of Nursing Service on providing care as outlined in the comprehensive care plan on March 20, 2012.

A Quality Assurance review will be conducted on all floors to identify other residents for whom the plan of care has not been properly followed and to ensure that staff is aware of documented interventions required by the plan of care. This audit will be reported to the Continuous Quality Improvement Committee.

The Continuous Quality Improvement Nurse (ADON) will conduct a Continuous Quality Improvement audit of resident's weights monthly for two months and then quarterly to ensure that all significant weight changes are being communicated appropriately. This audit will be reported to the Continuous Quality Improvement Committee.

The Continuous Quality Improvement Nurse (ADON) shall conduct quarterly CQI audits of residents with significant weight changes to ensure that care plan interventions are performed by nursing staff for residents as required by the Plan of Care. This audit will be reported to the Continuous Quality Improvement Committee.
**THE KING'S DAUGHTERS AND SONS**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 325</td>
<td>Continued From page 23</td>
<td>the significant weight loss of 5.06%. The RD stated, &quot;...Evidently not... no...&quot;</td>
<td>F 325</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| F 328 | 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS | The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.

This REQUIREMENT is not met as evidenced by:
- Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure there was a current physician's order for oxygen therapy and oxygen was administered at the physician's prescribed rate for 2 of 4 (Residents #1 and 2) sampled residents receiving oxygen therapy.

The findings included:

1. Review of the facility's oxygen administration policy documented, "...PROCEDURE... Check physician's order for liter flow and method of administration..."

2. Medical record review for Resident #1 documented an admission date of 11/18/11 with diagnoses of Hyponatremia, Dehydration, Urinary

The King's Daughters and Sons Home shall ensure that each resident receives proper treatment and care for special services to include injections; parenteral and enteral fluids; colostomy, ureterostomy, and ileostomy care; tracheostomy care; tracheal suctioning; respiratory care; foot care; and prostheses. This shall also include administration of oxygen.

Charge Nurses failed to transcribe physician orders for oxygen to the recertification orders for Resident #1 and Resident #2.

Charge Nurses received in-service training on March 20, 2012 regarding properly transcribing orders for the recertification orders.

The oxygen flow rate for Resident #2 has been corrected and the Resident is now receiving oxygen per the physician order.

The oxygen order for Resident #1 has been discontinued.

(F 328 continued on the next page)
Continued From page 24

Tract Infection, Hypertension, Cerebrovascular Accident, End Stage Parkinson's and Dementia.
Review of a physician's order dated 12/19/11 documented, "...O2 [oxygen] at 2l [liters] BNC [binalsal cannula] pm [as needed] dyspnea or O2 sat [saturation] < [less than] 93% [percent]..."
Review of the recertification orders dated 3/12/12 did not include an order for the use of oxygen.

Observations in Resident #1's room on 3/12/12 at 9:32 AM, 2:15 PM and 5:00 PM, revealed Resident #1 receiving oxygen through binalsal cannula at a rate between the marks for 1 and 1 1/2 liters per minute.

Observations in Resident #1's room on 3/13/12 at 8:15 AM and 11:00 AM, revealed Resident #1 receiving oxygen through binalsal cannula at 1 liter per minute.

Observations in Resident #1's room on 3/14/12 at 7:45 AM, revealed Resident #1 receiving oxygen through binalsal cannula at 1 1/2 liters per minute.

During an interview in the Director of Nursing's (DON) office on 3/13/12 at 9:37 AM, Nurse #3 was asked, "is there an order for oxygen on the current recertification orders for [Resident #1's name]?" Nurse #3 stated, "...they [nurses] didn't write it [oxygen orders] on here..."

During an interview in Resident #1's room on 3/14/12 at 7:50 AM, Nurse #5 confirmed Resident #1 was receiving oxygen at 1 1/2 liters per minute.

3. Medical record review for Resident #2 documented an admission date of 6/13/11 with a
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)

(x5) COMPLETION 
DATE

ID 
PREFIX 
TAG

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

F 328 Continued From page 25
readmission date of 12/8/11 with diagnoses of 
Coronary Artery Disease, Chronic Obstructive 
Pulmonary Disease, Chronic Respiratory 
Insufficiency, Hypertension, Diabetes Mellitus and 
Congestive Heart Failure. Review of the 
recertification orders dated 3/12/12 documented 
o no order for oxygen or for a bilevel positive airway 
pressure (BIPAP) machine. Review of the 
physician's orders dated 11/21/11 documented, 
"BIPAP FLOW RATE [PAP [inspiratory positive 
airway pressure] 14 EPAP [expiratory positive 
airway pressure] 8 - EVERY NIGHT AT 
BEDTIME... 02 @ (at) 3L [liters] / [per] MIN 
[minute] PER NASAL CANNULA 
CONTINUOUSLY...

Observations in Resident #2's room on 3/12/12 at 
10:00 AM, 2:20 PM and 5:00 PM, on 3/13/12 at 
8:20 AM and 12:05 PM and on 3/14/12 at 7:53 
AM, revealed Resident #2 receiving oxygen 
through binastral cannula at 2 liters per minute.

During an interview in the DON's office on 
3/13/12 at 9:45 AM, the DON was asked, "Is 
there an order for oxygen or for the BIPAP 
machine on the current recertification orders for 
[Resident #2's name]?" The DON stated, 
"...nurses should transcribe it [order for oxygen 
and BIPAP machine] on the next orders... it was 
never transferred over... it [Resident #2's oxygen 
flow rate] should be at 3 liters..."

During an interview in Resident #2's room on 
3/14/12 at 8:00 AM, Resident #2 confirmed that 
he received oxygen therapy through the BIPAP 
machine every night at bedtime.

F 371 483.35(I) FOOD PROCURE, 
SS= : STORE/REPAIR/SERVE - SANITARY

F 371: (F 371 started on next page)
F 371 Continued From page 26

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:

Based on policy review, observation and interview, it was determined the facility failed to ensure food was stored or prepared under sanitary conditions as evidenced by improper storage of cleaning cloths, dirty kitchen equipment, open food containers not dated and expired food during 2 of 2 (3/12/12 and 3/13/12) days of observation in the kitchen.

The findings included:

1. Review of the facility’s "Sanitization" policy documented, "...3. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions... 6. Between uses, cloths and towel used to wipe kitchen surfaces will be soaked in containers filled with approved sanitizing solution... 11. For fixed equipment or utensils that do not fit in the dishwashing machine, washing shall consist of the following steps: Equipment will be disassembled as necessary to allow access of

F 371 (F 371 started from the previous page)

The King's Daughters and Sons Home will store, prepare, distribute and serve food under sanitary conditions.

The Dietary Manager and Registered Dietician performed an inspection of the kitchen on March 12, 2012. All dirty kitchen equipment was immediately cleaned. All food items found to be stored open, expired or without a date were immediately discarded.

The on duty dietary staff was instructed on March 14, 2012 by the Dietary Manager regarding food receiving and storage and proper sanitation procedures, which included education on proper storage of kitchen towels used for cleaning and sanitizing.

All cleaning cloths and food items were checked for proper storage on 3-14-2012.

All dietary staff will receive in-service on food receiving and storage and proper sanitation procedures. These topics have also been added to the mandatory in-service schedule for the dietary department for the year.

(F 371 continued on next page)
F 371 Continued From page 27

the detergent/solution to all parts; Removable components will be scraped to remove food particle accumulation and washed according to manual or dishwashing procedures."

Review of the facility's "Food Receiving and Storage" policy documented, ".6. Dry foods that are stored in original packaging will be labeled and dated when received and re-dated when opened. 7. All items with "use by" dates will be monitored weekly and discarded prior to expiration. 8. All foods stored in the refrigerator or freezer will be covered, labeled and dated..."

Observations in the kitchen on 3/12/12 at 9:10 AM, revealed the following:

a. The Robo Coupe (mixer) had orange particles on the blades.

b. The meat slicer had a dried brown substance under the lip of the meat holder.

c. The pantry fridge had diet vanilla pudding dated 3/7/12, diet chocolate pudding dated 3/7/12, regular chocolate pudding dated 3/7/12, lemon pudding with no date, potato salad container open with no date and pimento cheese container open with no date.

d. The dry storage room had 1 box of potato pearls open with no date, 1 box of augatam potatoes open with no date, 1 bag of biscuit gravy mix open with no date, 2 containers of apple thickened liquid drink with an expiration date of 7/8/11 and 11 containers of orange juice thickened liquid drink with an expiration date of 11/1/11.

During an interview in the kitchen on 3/12/12 at 9:15 AM, the Director of Food Service confirmed all unclean findings of equipment, open and not
F 371  Continued From page 28

dated food containers and expired food. The Director of Food Service stated, "...The Robo
Coupe is dirty and should have been washed in the high temperature washer... The meat slicer
has not been used in over 2 days, that is dried piece of meat and it is not okay... The pudding
should have been pulled out of use only good for three days and expect containers to be dated
when opened... Yes, those liquids have expired and should have been thrown out and those
boxes of potatoes are open with no date of when opened..."

2. Review of the facility's "Kitchen Towels" policy
documented, "...Towels for cleaning and
sanitizing must be kept in a sanitation bucket
when not in use..."

Observations in the kitchen on 3/13/12 at 11:15
AM revealed, a wet towel on the prep table
beside the steamer and a wet towel on the prep
table beside the sink.

During an interview in the kitchen on 3/12/12 at
9:15 AM, the Director of Food Service confirmed
"... The sanitizer towel should be stored in the
sanitizer bucket when not in use..."

F 431  483.60(b), (d), (e) DRUG RECORDS,
LABEL/STORE DRUGS & BIOLOGICALS

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

F 431  The King's Daughters and Sons Home
shall ensure medications are properly
stored and labeled in accordance with
currently accepted professional
principles. Medications shall not be
stored past their open/expiration date.

(F 431 continued on next page)
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on review of the "MED-PASS MEDICATIONS WITH SHORTENED EXPIRATION DATES" provided by the American Society of Consultant Pharmacists, observation and interview, it was determined the facility failed to ensure medications were not stored past their open/expiration date or labeled in 2 of 10 (North 1 medication room and North 2 medication cart) medication storage areas and in Resident #1's room.

The vial of Novolin Regular® insulin had been opened by an agency nurse during the 11 – 7 shift. The nurse should have placed an “open” date on the vial. The vial was taken out of service and properly disposed of following discovery that there was no open date on it.

The expired 10 count card of Tamiflu was properly disposed of following discovery that it was out of date. The card had somehow been overlooked in the cart.

The Director of Nursing Service in conjunction with the Consultant Pharmacist shall conduct an in-service with all nurses regarding proper drug storage, labeling, handling and disposal of out dated medications.

All medications carts have been auditioned by the Director of Nursing Service to ensure that no out dated medications are in the carts.

(F 431 continued on next page)
F 431 Continued From page 30

The findings included:

1. Review of the "MED-PASS MEDICATIONS WITH SHORTENED EXPIRATION DATES" provided by the American Society of Consultant Pharmacists documented, ". . . The following EXPIRATION DATES of insulin vials begin AFTER OPENING / PUNCTURING... Novolin = [equals] 30 days."

Observations in the North 1 medication room on 3/13/12 at 12:25 PM revealed an open vial of Novolin Regular (R) insulin with a delivery date of 1/13/12 and no documented open date.

During an interview in the North 1 medication room on 3/13/12 at 12:25 PM, Nurse 32 was asked how long opened insulin could be used. Nurse #2 stated, "28 days." Nurse #2 confirmed there was no open date on the vial of Novolin R insulin and did not know how long it had been opened.

2. Observations in the North 2 hall on 3/14/12 at 9:12 AM, revealed a 10 count card of Tamiflu with an expiration date of 9/16/10 in the North 2 hall medication cart.

During an interview on the North 2 hall on 3/14/12 at 9:20 AM, Nurse #1 confirmed the 10 count card of Tamiflu was out of date and stated, "...that should be sent back..."

3. Observations in Resident #1's room on 3/14/12 at 7:45 AM, revealed an unlabeled 30 cubic centimeter (cc) cup filled with white cream on the resident's bedside dresser.

F 431 Continued

Medicated creams will only be provided to the CNA's when they are to be applied. Direction has been made to the Night Nursing Charge Nurse to discontinue putting medicated creams in medicine cups and leaving them in resident rooms. No creams shall be left in medicine cups in the resident room. This will be emphasized during the in-service with our Pharmacist.

The Continued Quality Improvement Nurse (ADON) shall conduct monthly Quality Assurance (CQI) audits of each medication cart to ensure that all outdated medications are disposed of properly for three months and then quarterly. The ADON will also conduct review of all opened vials of insulin to ensure that they are dated properly as to when they were opened. Results of these audits will be reported to the Quality Assurance Committee.
F 431 Continued From page 31

During an interview in Resident #1's room on 3/14/12 at 7:50 AM, Nurse #5 was asked to identify the cream in the 30 cc cup. Nurse #5 stated, "...it's Calmoseptine cream... it shouldn't be there..."

F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

F 441 The King's Daughters and Sons Home shall establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection.

All personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.

Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies.

All certified nursing assistants received a copy of the facility Hand washing/Hygiene 3/15/2012 Policy and Procedure on March 15, 2012.

Small group in-services will be conducted by the ADON to ensure that each employee is retrained on the Hand washing/Hand Hygiene. Training will be completed by March 30, 2012. All employees shall be trained and regularly

(F 441 continued on next page)
(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on policy review, medical record review, observation and interview, it was determined the facility failed to ensure practices to prevent the spread of infection were maintained when 4 of 13 Certified Nurse Assistants (CNAs #1, 2, 5 and 7) failed to practice sanitary hand hygiene during dining and CNA #3 and CNA #4 failed to wear appropriate personal protective equipment in an isolation room or failed to appropriately store equipment from the isolation room.

The findings included:

1. Review of the facility's "Handwashing/Hand Hygiene" policy documented, "...5. Employees must wash their hands for 15 seconds using antimicrobial or non - antimicrobial soap and water under the following conditions: a. Before and after direct contact with residents... f. Before and after eating or handling food; and before and after assisting resident with meals... b. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% [percent] ethanol or isopropanol for all the following situations... p. After contact with objects (medical equipment) in the immediate vicinity of the resident..."

(F 441 Continued)

in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.
In addition to Standard Precautions, all personnel shall implement Contact Precautions for residents known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment.

The DON will ensure that the appropriate notice is on the room entrance door so that 3/20/2012 all personnel will be aware of precautions, and that all necessary equipment and supplies will be available in the room needed during the period of Transmission-Based Precautions.

Small group in-services will be conducted by the ADON to ensure that each 3/30/2012 employee is retrained on the Isolation Policy and Procedure. Training will be completed by March 30, 2012.

The charge nurses will oversee the certified nursing assistants to ensure that the infection control policies are being 4/12/2012 properly executed. Any negative findings will be corrected immediately.

(F 441 continued on next page)
<table>
<thead>
<tr>
<th>(X4) 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 DEFINITION)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 441</td>
<td>Continued From page 33</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Observations during dining observations on the North 1 hall on 3/12/12 beginning at 5:30 PM, revealed CNA #1 carried a meal tray into room 208, set up the tray and rubbed the resident's back. CNA #1 returned to the meal cart, removed a meal tray and carried it into room 207 without performing hand hygiene. CNA #1 moved the overbed table, opened the items on the tray and placed a clothing protector on the resident. CNA #1 returned to the meal cart, removed a meal tray without and carried it to a resident in the day room and set up the tray without performing hand hygiene. CNA #1 returned to the meal cart, removed a meal tray and carried it into room 213 and began feeding the resident without performing hand hygiene or handwashing. After feeding the resident in room 213, CNA #1 returned to the meal cart and removed a meal tray and carried it into room 212. CNA #1 moved the resident's water pitcher, overbed table, wheelchair and raised the head of the bed. CNA #1 went into the bathroom and washed her hands then pressed the lever of the paper towel dispenser with clean hands to obtain paper towels. CNA #1 fed the resident then went to room 218 entered the bathroom and washed her hands. CNA #1 turned the water faucet off with her bare hands then pressed the lever for paper towels with her bare hands. CNA #1 returned to the room and moved the overbed table, raised the head of the bed, uncovered the meal tray and began feeding the resident with contaminated hands.

3. Observations during dining observations on North 2 hall on 3/13/12 at 12:24 PM, CNA #2 went into room 253, placed tray on the table,
Continued From page 34

positioned the resident's bed, uncovered the plate and cups. CNA #2 did not perform hand hygiene. CNA #2 returned to the meal cart, removed a meal tray, entered room 252 placed tray on table, moved resident's wheelchair, moved table up to the resident, lifted lid from plate and set tray up for resident. CNA #2 did not perform hand hygiene.

4. Observations during dining observations on the South 1 hall on 3/12/12 at 5:14 PM, CNA #5 entered room 101, placed the tray on the table, moved the oxygen concentrator, assisted the resident up on the bedside, moved the table to the resident and set up the tray. CNA #5 did not perform hand hygiene prior to setting up the tray.

5. Observations on the South 1 hall during dining observations on 3/12/12 at 5:26 PM, revealed CNA #7 entered room 109, placed the tray on the table, removed the wheelchair foot rest, moved the table and removed the lid from the plate. CNA #7 did not perform hand hygiene prior to touching the plate.

6. During an interview in the conference room on 3/14/12, at 1:45 PM, the Director of Nursing (DON) was asked what her expectation was for handwashing during meal service. The DON stated, "Hand sanitizer in between residents and wash [hands] every third time..."

7. Review of the facility's "Contact Precautions" policy documented, "...In addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact with the resident or..."
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
</table>
| F441 | Continued From page 35 | indirect contact with environmental surfaces or resident-care items in the resident's environment... c. Gown (1) In addition to wearing a gown as outlined under Standard Precautions, wear a gown (clean, nonsterile) for all interactions that may involve contact with the resident or potentially contaminated items in the resident's environment..." Medical record review for Resident #2 documented an admission date of 6/13/11 with a readmission date of 12/8/11 with diagnoses of Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, Chronic Respiratory Insufficiency, Hypertension, Diabetes Mellitus and Congestive Heart Failure. Review of a physician's order dated 2/11/12 documented, "...Isolation start VRE [vancomycin-resistant enterococcus] in urine C+S [culture and sensitivity] result..." Review of a laboratory result from a urine culture collected on 2/22/12 documented, "...Source: URINE...Methicillin resistant Staph [Staphylococcus] aureus..." Review of the physician's orders dated 3/12/12 documented, "...Isolation..." Observations in Resident #2's room on 3/12/12 at 2:25 PM, revealed CNAs #3 and 4 entered Resident #2's room without a gown and assisted transferring Resident #2 from the bed to the chair with a lift. CNA #3 and 4's clothes came into contact with the resident's clothes, the resident's bed linens and the resident's chair. Observations in Resident #2's bathroom on 3/12/12 at 10:00 AM and 2:20 PM and on 3/14/12 at 7:53 AM, revealed a graduated cylinder on the back of the toilet uncovered and unlabeled.
During an interview in Resident #2's bathroom on 3/12/12 at 2:30 PM, CNA #4 confirmed the graduated cylinder was used to empty Resident #2's urinary catheter.

During an interview in the Director of Nursing's (DON) office on 3/14/12 at 9:48 AM, the DON was asked what precautions the facility staff should take when entering an isolation room. The DON stated, "...gloves and gown when directly contacting resident with care..." The DON was asked how a graduated cylinder used to empty a urinary catheter should be stored. The DON stated, "...should be in a plastic bag... labeled with a resident's name..."

The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

This REQUIREMENT is not met as evidenced by:
Based on policy review, observation and interview, it was determined the facility failed to monitor the refrigerator freezer temperatures in the nourishment rooms for 4 of 4 (North 1 hall, South 1 hall, South 2 hall and North 2 hall) resident halls.

The findings included:
1. Review of the facility's "Food Receiving and Storage" policy documented, "...Food items and snacks kept on the nursing units must be..."
F 456 Continued From page 37

   continued

2. Observations in the North 1 hall nourishment room on 3/13/12 at 12:20 PM, revealed the refrigerator freezer containing ice cream with no thermometer.

   During an interview in the North 1 hall nourishment room on 3/13/12 at 12:20 PM, Nurse #1 stated, "We don’t check the freezer [temperature readings for the freezer]." Nurse #1 confirmed there was no thermometer in the freezer.

3. Observations in the South 1 hall nourishment room on 3/14/12 at 9:00 AM, revealed the refrigerator freezer with no thermometer.

4. Observations in the South 2 hall nourishment room on 3/14/12 at 9:10 AM, revealed the refrigerator freezer containing ice cream with no thermometer.

5. Observations in the North 2 hall nourishment room on 3/14/12 at 9:15 AM, revealed the refrigerator freezer with no thermometer.

F 514

F 514: The King’s Daughters and Sons Home shall ensure that clinical records are maintained on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

(F 514 continued on the next page)
F 514 Continued From page 38

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.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and interview, it was determined the facility failed to ensure physician's orders for laboratory (lab) tests were accurate; complete bowel movement (BM) records were in medical records and quarterly dietary documentation was completed for 5 of 21 (Residents #2, 5, 7, 9 and 17) sampled residents.

The findings included:

1. Medical record review for Resident #2 documented an admission date of 6/13/11 with a readmission date of 12/8/11 with diagnoses of Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, Chronic Respiratory Insufficiency, Hypertension, Diabetes Mellitus and Congestive Heart Failure. Review of a physician's order dated 6/20/11 documented, "...BMP [Basic Metabolic Panel] in 2 weeks then q every 6 mos [months] (March, Sept [September])... CMP [Comprehensive Metabolic Panel], CBC [Complete Blood Count] q 6 mos (June, Dec [December])... HgbA1C [Hemoglobin A1C] q 3 mos (March, June, Sept, Dec)..." Review of the physician's orders dated 3/12/12 did not include orders for routine laboratory (lab) work. Review of lab test results revealed results for the following (F 514 Continued)

ADL sheets for residents #5, #7, #17 documenting BM records are missing for the month of December. The December ADL sheets for residents of 2 South cannot be located. ADL sheets are pulled from the ADL Book by the night shift at the end of the month for filing in each resident's medical record by the medical records clerk. We cannot determine what happened to these sheets for the month of December for this floor.

The Director of Nursing Service has implemented a new system for pulling the ADL sheets which will prevent this situation from occurring in the future.

Resident #2 was hospitalized and upon his return to the facility his order for lab work was not transcribed to the recertification orders. This has been corrected for the month of April 2012.

F 514 Continued on the next page

The Director of Nursing Service shall cause a Quality Assurance Audit (Continuous Quality Improvement (CQI)) to be conducted on all medical records to ensure that monthly recertification orders properly reflect current physician orders.
Continued From page 39

labs that were drawn: 10/20/11 - CBC, CMP and HgbA1C, 11/3/11 - BMP, 12/2/11 - CBC, CMP and HgbA1C and 3/1/11 - BMP.

During an interview in the conference room on 3/14/12 at 1:24 PM, the Assistant Director of Nursing (ADON) confirmed Resident #2's routine lab orders were not on the current recertification orders. The ADON was asked, "Would you expect to see the routine lab orders on the recertification orders?" The ADON stated, "Yes."

2. Medical record review for Resident #5 documented an admission date of 10/1/99 with diagnoses of Vascular Dementia, Benign Hypertension, Cerebrovascular Accident and Peripheral Arterial Disease. Review of the medical record had no BM record for December 2011.

During an interview in the conference room on 3/14/12 at 9:50 AM, the DON was asked if Resident #5's December 2011 BM record was located. The DON stated, "No."

3. Medical record review for Resident #7 documented an admission date of 3/29/10 with diagnoses of Tricuspid Valve Disease, Cerebrovascular Disease, Peripheral Vascular Disease and Depression. Review of the medical record documented no BM record for December 2011.

During an interview in the conference room on 3/14/12 at 9:50 AM, the DON was asked if Resident #7's December 2011 BM record was located. The DON stated, "No."

Any omissions found will be corrected immediately. Licensed nurses received in-service education on ensuring all physician orders are transcribed to the recertification orders for each resident on March 20, 2012.

Nutrition Assessments shall be performed quarterly on all residents. Assessments for Resident #9 for September 2011 and December 2011 cannot be located. The Registered Dietician was not properly notified that quarterly assessments were due for Resident #9.

The Director of Nursing Service has created a RD Communication Book on each floor to ensure that the RD receives communications regarding when assessments are due. The system for notifying the RD when assessments are due has been reviewed and revised by the MDS Coordinator to ensure that the RD is notified when assessments are due.

The Director of Nursing Service shall cause a Quality Assurance Audit (Continuous Quality Improvement (CQI)) to be conducted on all medical records to ensure that dietary assessments are current.

(F 514 continued on the next page)
4. Medical record review for Resident #9 documented an admission date of 6/14/11 with diagnoses of Fracture Neck of Femur, Senile Dementia, Congestive Heart Failure, Osteoporosis and Osteoarthritis. Review of the "NUTRITION CARE PROCESS DOCUMENTATION" dated 6/14/11 documented an admission nutrition assessment. Review of the "QUARTERLY PROGRESS DATA" documented a quarterly note on 2/16/12. The facility was unable to provide documentation of quarterly nutrition assessments for September 2011 and December 2011.

During an interview at the North 1 hall nurses' station on 3/13/12 at 10:55 AM, the Registered Dietician (RD) was asked about the quarterly nutrition assessments. The RD stated, "I think it was during the time they had a tech [technician] helping. I only worked one day a week. I wouldn't have known about quarterly unless they told me it was coming up."

During an interview in the conference room on 3/14/12 at 1:42 PM, the RD was asked how often dietician should chart. The RD stated, "...At least quarterly and sometimes more often..."

5. Medical record review for Resident #17 documented an admission date of 2/25/11 with diagnoses of Esophageal Reflux, Atony of the Bladder, Schizoaffective and Diabetes Mellitus Type II. Review of the medical record had no BM record for December 2011.

During an interview in the conference room on 3/14/12 at 9:50 AM, the DON was asked if Resident #17's December 2011 BM record was
<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>
</tr>
</thead>
<tbody>
<tr>
<td>F 514</td>
<td>Continued From page 41 located. The DON stated, “No.”</td>
<td>F 514.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**RECEIVED**

Date: 2/25/12