STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:

445221

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
01/06/2011

NAME OF PROVIDER OR SUPPLIER
THE KINGS DAUGHTERS AND SONS

STREET ADDRESS, CITY, STATE, ZIP CODE
3568 APPLING ROAD
BARTLETT, TN 38133

(X4) ID PREFIX TAG
F 278

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

F 278

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

The assessment must accurately reflect the resident's status.

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

A registered nurse must sign and certify that the assessment is completed.

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

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

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview, it was determined the facility failed to ensure the Minimum Data Set (MDS) was accurate for a medical diagnosis for 1 of 21 (Resident #9) sampled residents.

The King's Daughters and Sons Home shall ensure that the assessment of each resident accurately reflects the resident's status. The Minimum Data Set (MDS) will be accurate for medical diagnosis of each resident.

The MDS and the comprehensive plan of care for resident #9 were reviewed and revised on 1/6/2011 to properly show the correct active diagnoses for resident #9.

Resident #9 was evaluated and no negative outcomes were sustained.

Since all residents have the potential to be affected, the MDS Coordinator will audit all Minimum Data Sets and medical records to ensure that the MDS properly reflects active diagnoses of residents. Any inaccuracies found will be researched and corrected immediately.

A meeting will be held with the care plan team members by the Administrator and CQI nurse (ADON) on 2/1/2011 to discuss proper documentation of the MDS and procure ideas of effective ways to improve our interdisciplinary systems.

(F 278 continued next page)

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

Ronald B. Arison

TITLE
Executive Director

DATE
1/26/2011

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.

FORM CMS-2557(02-92) Previous Versions Obsolete
Event ID: DXX11
Facility ID: TN7930
If continuation sheet Page 1 of 21
<table>
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<tr>
<th>ID</th>
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| F 278 |  | Continued From page 1  
The findings included:  
Medical record review for Resident #9 documented an admission date of 1/9/03 and a readmission date of 2/27/07 with diagnoses of Quadriplegia, Sacral Pressure Ulcer Stage 4, Reflux Esophagitis, Depressive Disorder, Peptic Ulcer, Hypertension and Urinary Retention. Review of the quarterly MDS with an assessment reference date of 10/25/10 documented, "...Section I Active Diagnoses... Diabetes Mellitus..."  
During an interview in the conference room on 1/5/11 at 9:20 AM, Nurse #4 reviewed the MDS and stated, "He [Resident #9] is not a diabetic. That [MDS] was wrong."  
| F 278 |  | (F 278 continued)  
The CQI Nurse (ADON) shall monitor and audit charts quarterly to ensure they are coded accurately. Results of these audits will be reported to the Quality Assurance Committee. The frequency and duration of further audits will be determined by the committee.  
| |
| F 280 | Ss=E | 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 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.  
| F 280 |  | (F 280 continued next page)  
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.  
Care plans for residents #2, # 3, # 6, #8, #10, #11, #16 and #18 were reviewed and revised to reflect each resident's current medical status as reflected in the medical record and physician orders.  

(F 280 continued next page)
This **REQUIREMENT** is not met as evidenced by:

Based on policy review, medical record review, observation and interview, it was determined that the facility failed to revise the comprehensive care plan to reflect the resident's current status for a Foley catheter for 8 of 21 (Residents #2, 3, 6, 8, 10, 11, 16 and 18) sampled residents.

The findings included:

1. Medical record review for Resident #2 documented an admission date of 1/7/09 with diagnoses of Cerebrovascular Accident, Decubitus Ulcer, Cardiac Dysrhythmia, Edema, Hypertension; Urinary Tract Infection, Hemiplegia, Dysphagia, Aphasia, Chronic Obstructive Disease, Congestive Heart Failure and Reflux Esophagitis. Review of the Minimum Data Set (MDS) with an assessment reference date of 1/15/10 documented Resident #2 had range of motion limitations on one side of the arm, hand, leg and foot. Review of the MDS with an assessment reference date of 10/14/10 documented Resident #2 had a limitation in ROM impairment on one side of the upper and lower extremities. Review of the care plan dated 1/19/10 revealed no documentation to address ROM limitations.

During an interview in the MDS office on 1/6/11 at 2:00 PM, Nurse #3 confirmed there was no care plan to address ROM.

2. Medical record review for Resident #3

(F 280 continued)

Resident #2, #3, #6, #8, #10, #11, #16 and #18 were evaluated and no negative outcomes were sustained.

Since all residents have the potential to be affected, effective 1/26/2011, changes in orders will be reviewed daily by the resident's nurse and care plans will be revised immediately to reflect the resident's current status. The MDS nurses and the ADON will receive copies of all physician orders and fall occurrence reports from the DON. Changes made to the care plan will be reviewed by the MDS nurses and care plans will be revised as necessary.

Any resident admitted with range of motion (ROM) limitations as reflected in nursing history or the physician's History and Physical will have ROM reflected in their care plan. In addition, the restorative aide has developed a worksheet of all residents receiving ROM and will copy the MDS nurses, ADON and DON weekly.

Computer QUB'S have been developed to aid in identifying therapeutic diets and the programs residents are receiving, i.e. restorative care, rehabilitation therapy.

(F 280 continued next page)
**continued**

Documented an admission date of 7/23/10 with diagnoses of Aphasia, Dysphagia, Depressive Disorder, Dementia, Gastrostomy and history of Cerebrovascular Accident. Review of a physician’s order dated 12/27/10 documented, "...DIET ORDERS PEG [Percutaneous Endoscopy Gastrostomy] TUBE FEEDING: ISO SOURCE HN @ [at] 40 ML [milliliters] /[per] H/R [hour]." Review of the comprehensive care plan reviewed on 11/8/10 documented, "...Potential for development of UTI [Urinary Tract Infection] r/t [related to] Foley catheter used for urine output. Self care deficit... Provide tray setup and encourage resident to feed self, only assist if resident can’t complete task..."

Observations in Resident #3’s room on 1/4/11 at 11:35 AM, revealed Resident #3 receiving Isosource HN per PEG infusing at 40 ml/hr. Resident #3 did not have a Foley catheter.

During an interview in the red hallway on 1/5/11 at 7:55 AM, Certified Nursing Assistant (CNA) #3 was asked if Resident #3 received a meal tray. CNA #3 stated, "No Ma’am. She [Resident #3] doesn’t eat. She is a PEG feeding."

During an interview in the red hallway on 1/5/11 at 3:40 PM, CNA #4 was asked if Resident #3 had a catheter. CNA #4 stated, "No she [Resident #3] doesn’t have a catheter. She hasn’t for a long time."

During an interview in the MDS office on 1/5/11 at 3:40 PM, Nurse #4 stated, "I coded the MDS, but I didn’t take the catheter off the care plan... She [Resident #3] doesn’t get a meal tray. I should have changed the care plan."
### F 280 (continued)

3. Medical Record Review for Resident #6 documented an admission date of 4/30/08 and an readmission date of 11/13/08 with diagnoses of Cerebrovascular Accident, Epilepsy, Dehydration, Late Effect Hemiplegia, Hypercholesteremia, Anxiety, Depression, Hypothyroidism, Hyperlipidemia, Hypertension and Osteoporosis. Review of the MDS with an assessment reference date of 9/23/10 documented Resident #6 had ROM limitation on one side of neck, arm, hand, leg, and foot. Review of the care plan dated 10/3/10 revealed no documentation to address ROM limitations.

During an interview in the MDS office on 1/6/11 at 2:00 PM, Nurse #3 confirmed there was no care plan to address ROM.


During an interview in the MDS office on 1/5/11 at 11:15 AM, Nurse #3 was asked if she would expect to have a care plan for ROM, when ROM was ordered for 12 weeks. Nurse #3 reviewed the care plan and stated, "Should [ROM] be on the
**F 280** Continued From page 5

care plan. I don’t see it.” Nurse #3 also stated, “Regular diet means no restrictions. I see she [Resident #8] should be on NAS diet as ordered. Missed that one [diet should be NAS not regular].”

5. Medical record review for Resident #11 documented an admission date of 4/12/99 and a readmission date of 6/16/04 with diagnoses of Gastrostomy Status, Osteoporosis, Epilepsy, Bone and Cartilage Disease, Aphasia, Head Injury, Closed Skull Fracture, Quadriplegia, Neurogenic Bladder and Urinary Retention. Review of the MDS with an assessment reference date of 10/14/10 documented Resident #11 had a limitation in ROM impairment on both sides of the upper and lower extremities. Review of the care plan dated 10/14/10 revealed no documentation to address ROM limitations.

During an interview in the MDS office on 1/8/11 at 2:00 PM, Nurse #3 confirmed there was no care plan to address ROM.

6. Review of the facility's "Falls Policy" documented, "...B. Documentation and Follow-up... 3. Refer to the interdisciplinary treatment team to review fall prevention interventions and modify care-plans as appropriate..."

a. Medical record review for Resident #10 documented an admission date of 6/7/07 and a readmission date of 8/5/10 with diagnoses of Fracture of Right Hip and Alzheimer's. Nurse's notes documented that Resident #10 had falls with no injuries on 8/17/10, 8/21/10, 9/23/10, 10/19/10 and 11/3/10. Review of the care plan dated 8/11/10 and 10/5/10 had no documentation of falls or interventions for the falls on 8/17/10,
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<th>(X5) COMPLETION DATE</th>
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| F 280       | Continued From page 8  
8/21/10, 9/23/10, 10/19/10 and 11/3/10.  
b. Medical record review for Resident #16 documented an admission date of 9/10/10 with diagnoses of Left Lower Extremity Weakness, Transient Ischemic Attack, Sepsis, Urinary Tract Infection, Deconditioning Atherosclerotic Heart Disease, Hypertension, Diabetes, Chronic Renal Failure, Stroke, Coronary Artery Bypass Graft and Dyslipidemia. Nurse's notes documented that Resident #16 had falls with no injuries on 11/18/10, 12/18/10 and 12/12/10. Review of the care plan dated 11/8/10 had no documentation of falls or interventions for falls on 12/18/10 and 12/12/10.  
During an interview in the conference room on 1/6/11 at 3:30 PM, Nurse #3 confirmed that standing interventions were being used for falls and that the Director of Nurses was going to start giving her the information to put on the care plans.  
c. Medical record review for Resident #18 documented an admission date of 11/4/10 with diagnoses of Chronic Obstructive Pulmonary Disease, Benign Prostatic Hypertrophy, Hypertension, Atrial Fibrillation, Left Hemiplegia and History of Cerebrovascular Accident. Nurse's Notes dated 12/6/10 documented, "...found Resident on his back on the bathroom floor..." Review of the comprehensive care plan dated 11/23/10 documented, "...Potential for falls..." There was no documentation on the comprehensive care plan of the fall that occurred on 12/6/10.  
During an interview in the conference room on 1/6/11 at 11:50 AM, the DON stated, "...He
Continued From page 7

[Resident #16] had a fall, but the intervention is not written down in the chart.

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 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, observations and interviews, it was determined the facility failed to follow physician's orders for the setting of an air mattress, therapeutic diets, elevating of extremities or the use of a lap buddy for 4 of 21 (Residents #5, 7, 9 and 12) sampled residents.

The findings included:

1. Medical record review for Resident #5 documented an admission date of 2/19/07 with diagnoses of Multiple Sclerosis, Pressure Ulcer to Heel, Diabetes Mellitus, Congestive Heart Failure and Senile Dementia. Review of the physician's orders dated 12/13/10 documented, "...CHECK SETTINGS ON AIR MATTRESS EVERY SHIFT. MAKE SURE ITS [air mattress is] SET ON 3-[to] 4..."

Observations in Resident #5's room on 1/5/11 at 2:55 PM and on 1/5/11 at 8:15 AM, revealed the air mattress setting was on 5.

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 orders are followed as written.

The physicians order for resident #5, #7, #9, and #12 were reviewed and care plans were revised as necessary to reflect each resident's current medical status as reflected in the medical record and physician orders.

Resident #5, #7, #9, and #12 were evaluated and no negative outcomes were sustained.

Resident #5 now has specific instructions for the proper settings of her air mattress taped onto the control box, and the proper setting (3-4) have been identified with tape. CNA's for this resident have been in serviced on the proper procedure for setting the mattress.

(F 309 continued next page)
F 309 Continued From page 8

During an interview in Resident #5's room on 1/6/11 at 8:35 AM, the Director of Nursing (DON) checked the setting of the air mattress and stated, "Set on more than 5 right now..."

2. Medical record review for Resident #7 documented an admission date of 7/11/07 with a current diagnoses of Right Above The Knee Amputation, Congestive Heart Failure and Hypertension. Review of a physician's order dated for 11/15/10 documented, "LAP BUDDY TO W/C [wheelchair] WHEN IN ROOM ONLY FOR PATIENT SAFETY, VISUAL CHECK RES [resident] WHEN IN W/C WITH LAP BUDDY Q [every] 30 MIN [minutes], RELEASE Q 2 HOURS FOR TOILETNG AND POSITIONING." Review of the care plan dated 1/12/10 documented, "lap buddy to Wheelchair when in room only for resident safety."

Observations in Resident #7's room on 1/5/11 at 11:05 AM and 3:20 PM, revealed Resident #7 in her room sitting up in w/c without a lap buddy in place as ordered.

During an interview at the yellow nurse's station on 1/6/11 at 3:20 PM, Nurse #6 confirmed that Resident #7's lap buddy should be used when Resident #7 is up in the w/c in her room.

3. Medical record review for Resident #9 documented an admission date of 1/6/03 and a readmission date of 2/27/07 with diagnoses of Quadriplegia, Sacral Pressure Ulcer Stage 4, Reflux Esophagitis, Depressive Disorder, Peptic Ulcer, Hypertension and Urinary Retention. Review of a physician's order dated 12/6/10 documented, "...DIET ORDERS NO BREAD OR ROLLS WITH MEALS ... CRANBERRY JUICE 1

F 309 (continued)

Charge nurses on each shift will audit all rooms of residents identified with air mattresses to ensure the mattress is set correctly.

Resident #7 now has specific instructions on proper use of her lap buddy posted in her room. CNA's were re-in serviced on ensuring restraints are applied in the appropriate manner and providing proper supervision when restraints are in use. Charge nurses on each shift will do random audits to ensure that lap buddy is used for patient safety only, when in room up in wheelchair.

Resident #9's clinical plan of care has been revised to comply with current dietician orders. All CNA's of this resident have been educated on these changes.

Resident #2's CNA's were re-in serviced to ensure that resident's lower extremities are elevated as ordered. Charge nurses on each shift will do random audits of resident to ensure orders are properly being followed.

Nursing staff shall follow all physician orders when providing care to residents. Since all residents have the potential to be affected, all CNA's... (F309 continued next page)
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<td>F 309</td>
<td>Continued from page 9</td>
<td>LARGE GLASS ON EACH MEAL TRAY...</td>
<td>(F309 continued)</td>
<td>1/24/2011</td>
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<td>Observations in Resident #9's room on 1/4/11 at 5:20 PM, revealed Resident #9 was served a roll with the evening meal and was not served cranberry juice as ordered.</td>
<td>will receive in-service training as to their responsibility to follow standards of practice and following physicians' orders.</td>
<td>1/24/2011</td>
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<td>During an interview at the resident's station on 1/5/11 at 12:15 PM, the Registered Dietician stated, &quot;He [Resident #9] gets bread and rolls with his meals. That order change was not carried over to the recertification orders. He should be getting the cranberry juice with his meals.&quot;</td>
<td>Changes in orders will be reviewed each day by the resident's nurse and care plans will be revised immediately to reflect the resident's current status.</td>
<td>1/24/2011</td>
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<td>4. Medical record review for Resident #12 documented an admission date of 9/27/01 with diagnoses of Quadriplegia, Osteomyelitis, Pressure Ulcer to Hip, Reflux Esophagitis, Urinary Tract Infection and Neurogenic Bladder. Review of a physician's order dated 12/13/10 documented, &quot;...ELEVATE BILATERAL LE [lower extremities].&quot;</td>
<td>A Continuous Quality Improvement audit of all medical records shall be conducted to identify other residents who might not be receiving care as ordered by the physician. Any negative findings will be corrected immediately.</td>
<td>1/24/2011</td>
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<td>Observations in Resident #12's room on 1/4/11 at 3:10 PM and on 1/5/11 at 2:55 PM, revealed Resident #12 lying in the bed with both legs flat on the bed. Resident #12's lower extremities were not elevated as ordered.</td>
<td>The CQI Nurse (ADON) will conduct monthly audits for three months to monitor adherence to all physicians' orders. The findings from the auditing and monitoring processes will be documented and submitted to the CQI committee for further review and corrective action. The CQI committee will determine frequency of audits after this time.</td>
<td>1/24/2011</td>
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<td>F 332</td>
<td>SS=0</td>
<td>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</td>
<td>(F332 started on next page)</td>
<td>1/24/2011</td>
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F 332 Continued From page 10

(F 332 started from previous page)

This REQUIREMENT is not met as evidenced by:
Based on review of "MED-PASS COMMON INSULINS" provided by the American Society of Consultant Pharmacist, policy review, medical record review, observations and interview, it was determined the facility failed to ensure 2 of 7 (Nurses #1 and 2) nurses administered medications with a medication error rate of less than 5 percent (%). A total of 3 errors were observed out of 45 opportunities for error, resulting in a medication error rate of 6.6%.

The findings included:

1. Review of the "MED-PASS COMMON INSULINS: Pharmacokinetics, Compatibility, and Properties" provided by the American Society of Consultant Pharmacist for typical dosing administration of insulin related to meals documented, "Novolin R... ONSET (In Hours, Unless Noted)... 0.5- to 1... TYPICAL DOSING / COMMENTS... 30 MINUTES BEFORE MEALS... Novolog... ONSET (In Hours, Unless Noted)... 15 min [minutes]... TYPICAL DOSING / COMMENTS... 5-10 minutes before meals..."

2. Review of the facility's "INSULIN ADMINISTRATION" Policy documented, "Regular insulin must not be given more than thirty minutes before a resident receives a meal tray... Humalog and Novolog insulin must not be given more than fifteen minutes before a meal tray..."

3. Observations in Resident #1's room on 1/4/11 at 3:50 PM, Nurse #1 administered 4 units of...
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<td>F332</td>
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<td>Novolin R insulin to Resident #1. Resident #1 did not receive his supper tray until 6:35 PM. The administration of the insulin 1 hour and 45 minutes before supper was served, resulted in medication error #1.</td>
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<td>4. Medical record review for Random Resident (RR) #1 documented an admission date of 10/6/09 with diagnoses of Cerebrovascular Accident, Hypoxemia, Acute Respiratory Failure, Urinary Incontinence, Pneumonia, Edema, Shortness of Breath, Angina and Depression. Review of a physician's order dated 12/20/10 documented, &quot;...NOVLOG 100 UNIT/ [per] ML [milliliters] VIAL... INJECT 6 UNITS SUB-Q [subcutaneously] THREE TIMES DAILY BEFORE MEALS...&quot;</td>
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<td>Observations in RR #1's room on 1/4/11 at 4:30 PM, Nurse #2 administered 5 units of Novolog insulin to RR #1. RR #1 did not receive her supper tray until 6:32 PM. The administration of the insulin 1 hour and 2 minutes before supper was served, resulted in medication error #2.</td>
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<td>5. Medical record review for RR #2 documented an admission date of 5/17/04 and a readmission date of 8/30/04 with diagnoses of Diabetes, Osteoarthritis, Cystitis, Pulmonary Insufficiency, Encephalopathy, Pulmonary Congestion, Urinary Tract Infection, Peritonitis, Anemia and Depression. Review of a physician's order dated 12/27/10 documented, &quot;...NOVOLIN R 100 UNITS/ML VIAL... SLIDING SCALE...201-250= [amount of insulin to be administered] 4U [units]... NOVOLIN R 100 UNITS/ML VIAL... INJECT 8 UNITS SUB-Q THREE TIMES DAILY BEFORE MEALS...&quot;</td>
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<td>F 332</td>
<td>Continued From page 12: Observations in RR #2's room on 1/4/11 at 4:55 PM, Nurse #2 administered 10 units of Novolin R insulin to RR #2. RR #2 did not receive her supper tray until 5:46 PM. The administration of the insulin 51 minutes before supper was served, resulted in medication error #3.</td>
<td>F 332</td>
<td>The King's Daughters and Sons Home shall ensure that the Home is free of significant medication errors.</td>
<td>1/07/2011</td>
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<td>F 333</td>
<td>483.25(m)(2) Residents Free of Significant Med Errors</td>
<td>F 333</td>
<td>The Director of Nursing Service instructed all nurses regarding proper insulin administration including proper time of administration before meals.</td>
<td>2/15/2011</td>
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The findings included:

1. Review of the "MED-PASS COMMON INSULINS: Pharmacokinetics, Compatibility, and Properties" provided by the American Society of Consultant Pharmacist for typical dosing administration of insulin related to meals documented, "Novolin R... ONSET (in Hours, Unless Noted)... 0.5- [to] 1... TYPICAL DOSSING /
F 333 Continued From page 13

2. Review of the facility's "INSULIN ADMINISTRATION" policy documented, "Regular Insulin must not be given more than thirty minutes before a resident receives a meal tray... Humalog and Novolog Insulin must not be given more than fifteen minutes before a meal tray..."

3. Observations in Resident #1's room on 1/4/11 at 3:50 PM, Nurse #1 administered 4 units of Novolin R insulin to Resident #1. Resident #1 did not receive his supper tray until 5:35 PM. The administration of the insulin 1 hour and 45 minutes before supper was served, resulted in a significant medication error.

4. Medical record review for Random Resident (RR) #1 documented an admission date of 10/5/09 with diagnoses of Cerebrovascular Accident, Hypoxemia, Acute Respiratory Failure, Urinary Incontinence, Pneumonia, Edema, Shortness of Breath, Angina and Depression. Review of a physician's order dated 12/20/10 documented, "...NOVOLOG 100 UNIT/ [per] ML [milliliters] VIA... INJECT 5 UNITS SUB-Q [subcutaneously] THREE TIMES DAILY BEFORE MEALS..."

Observations in RR #1's room on 1/4/11 at 4:30 PM, Nurse #2 administered 5 units of Novolog insulin to RR #1. RR #1 did not receive her supper tray until 5:32 PM. The administration of the insulin 1 hour and 2 minutes before supper was served, resulted in a significant medication error.
**F 333** Continued From page 14

6. Medical record review for RR #2 documented an admission date of 5/17/04 and a readmission date of 8/30/04 with diagnoses of Diabetes, Osteoarthritis, Cystitis, Pulmonary Insufficiency, Encephalopathy, Pulmonary Congestion, Urinary Tract Infection, Peritonitis, Anemia and Depression. Review of a physician's order dated 12/27/10 documented, "...NOVOLIN R 100 UNITS/ML VIAL... SLIDING SCALE ...201-250=[amount of insulin to be administered] 4U [units]... NOVOLIN R 100 UNITS/ML VIAL... INJECT 8 UNITS SUB-Q THREE TIMES DAILY BEFORE MEALS..."

Observations in RR #2's room on 1/4/11 at 4:55 PM, Nurse #2 administered 10 units of Novolin R insulin to RR #2. RR #2 did not receive her supper tray until 5:48 PM. The administration of the insulin 51 minutes before supper was served, resulted in a significant medication error.

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**F 371**

483.35(F) FOOD PURCHASE, STORE/PREPARE/SERVE - SANITARY

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

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**F 371**

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

The Dietary staff was in-serviced by the Dietary Manager regarding employee hygiene and proper sanitation procedures which included education on hair nets and beard restraints being worn to keep hair from contacting exposed food, clean equipment, utensils and linen. The Dietary Manager procured and is wearing a beard cover while in the kitchen.

(F 371 continued on next page)
**STATEMENT OF DEFIENCIES AND PLAN OF CORRECTION**

**X1** PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: 445221

**(X2) MULTIPLE CONSTRUCTION**

A. BUILDING: 
B. WING: 

**X3** DATE SURVEY COMPLETED: 01/06/2011

**NAME OF PROVIDER OR SUPPLIER:**

**THE KINGS DAUGHTERS AND SONS**

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

3938 APPLING ROAD
BARTLETT, TN 38133

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<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tr>
<td>F 371</td>
<td>Continued From page 15</td>
<td>F 371</td>
<td>(F 371 continued) The stove, hood of stove, and grease trap of stove were immediately cleaned. To prevent this deficient practice from reoccurring the general inspection of the stove, including the hood and grease trap, will be done daily and cleaned as often as is necessary. Additional cleaning will be scheduled on a monthly basis to be performed by a dietary staff member. Additional shelves and racks were added to the dish room providing more drying space to prevent wet nesting of glasses. Immediate correction for the dish washer was made by replacing two heating elements of the dish machine to ensure water temperatures are maintained at the proper levels. Policy and procedures for proper dishwashing machine operation were updated. A log was put in place to indicate checking the dish machine two times per day. The Dietary Manager will be present during at least one check per week, or will conduct a separate check to validate process. Dietary procedures for maintaining standards for sanitary conditions and employee hygiene were updated to include these tasks and policies and cleaning schedules will be updated to reflect these changes. (F 371 continued next page)</td>
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<td>F 371</td>
<td>Continued From page 16 Observations in the kitchen on 1/5/10 at 4:45 PM, revealed a dietary worker in the kitchen without a cover on his head. 2. Review of the facility's &quot;Dishwashing Machine Use/Sanitation Procedure&quot; documented, &quot;Food Service staff required to operate the dishwashing machine will be trained in all steps of dishwashing machine use by the supervisor or a designee proficient in all aspects of proper use and sanitation... 2. Dishwashing machines that use hot water to sanitize must maintain the following wash solution temperatures: a. Wash 150- [to] 165 degrees F [Fahrenheit]...&quot; Review of the facility's &quot;DISHMACHINE TEMPERATURE LOG HOT WATER TYPE&quot; dated for January, 2011 documented the final rinse temperatures for breakfast, lunch and dinner. There was area on the log for documentation of the wash temperatures. Review of the manufacture's guidelines on the side of the facility's dishmachine for a high temperature machine documented that the minimum wash temperature for the dishmachine was 150 degrees F. Observations in the kitchen on 1/5/10 beginning at 8:50 AM revealed two wash cycles revealed the wash temperature was 140 degrees F. During an interview in the kitchen on 1/5/10 at 8:50 AM with the dietary manager confirmed that the temperature on the dishwasher was not at the required 150 degrees F.</td>
<td>F 371</td>
<td>(F 371 continued) Dietary staff was in-serviced on proper sanitation practice, including prevention of wet nesting, and the proper use of the dishwasher. The Dietary Manager will monitor temperature logs daily for three weeks, three times per week for two weeks, then weekly to ensure completion of logs. Results of inspections will be reported quarterly to the CQI Committee. The Dietary Manager or his designee shall inspect the kitchen each day to ensure that food items are stored, prepared, distributed and served under sanitary conditions. The Dietary Manager will audit weekly for three weeks to assure compliance is maintained. After 3 weekly reviews audits will be done monthly until such time as it is determined that the department is fully in compliance. Audits will be reported to the Continuous Quality Improvement Committee for quarterly review. The CQI committee will monitor results and ensure consistency and compliance.</td>
<td>1/06/2011</td>
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<td>F 441</td>
<td>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</td>
<td>F 441</td>
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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.

(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:

(F 441 started)

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. The facility will establish an infection control program under which we investigate, control, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.

Staff was re-instructed regarding proper hand hygiene and keeping meal trays which have been served separate from trays that have not been served.

Infection control policies were reviewed and revised. These policies include, but are not limited to, hand washing, medication administration and food service.

All applicable staff will be re-instructed on infection control protocols. Training will include proper handling of meal trays and all aspects of hand hygiene.

(F 441 continued next page)
Continued From page 18

Based on policy review, observations and interviews, it was determined the facility failed to ensure practices to prevent the potential spread of infection was maintained when 1 of 7 (Nurse #2) nurses failed to practice handwashing and 2 of 5 Certified Nursing Assistants (CNA #1 and #2) placed contaminated trays back on the cart with trays that had been served or served trays from the contaminated meal cart.

The findings included:

1. Review of the facility's "Handwashing/Hand Hygiene" policy documented, "...If hands are not visibly soiled, use an alcohol-based hand rub... for all the following situations...b. After removing gloves..."

Observations in room 141 on 1/4/11 at 4:30 PM, revealed Nurse #2 donned gloves, performed a fingerstick for a blood sample, and removed the gloves. Nurse #2 donned gloves again and cleaned the glucometer. Nurse #2 did not practice hand hygiene before or after the use of gloves.

Observations in room 150 on 1/4/11 at 4:45 PM, revealed Nurse #2 donned gloves, performed a fingerstick for a blood sample, and removed the gloves. Nurse #2 donned gloves again and administered insulin into the resident's abdomen. Nurse #2 did not practice hand hygiene before or after the use of gloves.

2. Observations in the yellow hallway on 1/4/11 beginning at 5:30 PM, a meal tray was placed in room 150. At 5:40 PM, CNA #2 took the tray from room 150 and placed it back on the meal cart with trays that had not yet been served.

(F 441 continued)

Charge nurses will oversee certified nursing assistants to ensure that infection control policies are being properly executed. Any negative findings will be corrected immediately.

The CQI Nurse (DON) will conduct weekly audits for one month during randomly selected meal times, med pass and daily rounds to ensure that infection control policies, including hand hygiene and food service, are being properly followed. If findings are conducive to our policy the audits will then be conducted monthly for two months. The findings from the auditing and monitoring processes will be documented and submitted to the CQI committee for further review and corrective action. The CQI committee will determine frequency of audits after this time.
**THE KINGS DAUGHTERS AND SONS**

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<td>F 441</td>
<td>Continued From page 19</td>
<td>During an interview on the yellow hall on 1/4/11 at 5:40 PM, CNA #2 stated, &quot;The tray should not be in the room until I'm ready to feed her.&quot; 3. Observations in the red hallway on 1/5/11 at 12:30 PM, revealed a meal tray that had been served was placed back on the cart beside a meal tray that had not been served. CNA #1 removed the unserved tray from the cart, carried the tray into a resident's room and served the meal to the resident. During an interview in the Director of Nursing's (DON) office on 1/6/11 at 3:10 PM, the DON stated, &quot;They [staff] know better than that. They shouldn't put a dirty tray on a cart with trays not served yet...&quot;</td>
<td>F 441</td>
<td>The King's Daughters and Sons Home shall ensure that written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents are in place and followed. This shall include ensuring required food is stocked in case of disaster.</td>
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<td>F 517</td>
<td>483.75(m)(1) WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS</td>
<td>The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that the required food was stocked in case of a disaster. The findings included: Observations in the kitchen storage room on 1/4/11 at 9:35 AM, revealed there was no three day emergency menu or emergency supply of food.</td>
<td>F 517</td>
<td>The Dietary Manager ordered and placed in service the required three day emergency supply of food in a separate area within the food storage area. The Continuous Quality Improvement Coordinator shall conduct quarterly CQI audits of emergency food supplies to ensure that the three day supply of emergency food is stocked. This audit shall be reported to the Continuous Quality Improvement Committee.</td>
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<td>F 517</td>
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<td>During an interview in the kitchen on 1/4/11 at 9:35 AM, the dietary manager confirmed that all the food in the kitchen would be used for an emergency. There was no separated emergency supply or menu.</td>
<td>F 517</td>
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If continuation sheet Page 21 of 21