

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185341	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/18/2011
NAME OF PROVIDER OR SUPPLIER GREEN ACRES HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 402 W. FARTHING STREET MAYFIELD, KY 42066		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 333	<p>Continued From page 31</p> <p>On 09/17/10 at 4:00 PM, Resident #14's accucheck result was 544 mg/dl. LPN #5 administered 16 units of Lantus insulin and 7 units of the sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #5 should have administered 14 units of the sliding scale Humalog insulin.</p> <p>On 09/18/10 at 4:00 PM, Resident #14's accucheck result was 151 mg/dl. LPN #5 withheld the Lantus insulin, without consulting with the resident's physician. LPN #5 should have administered 16 units of Lantus insulin as ordered.</p> <p>2. Review of the physician's orders revealed on 09/20/10, the routine Lantus insulin was changed to 12 units in the afternoon. Review of the resident's Diabetic Record from 09/20/10 through 10/05/10 and follow-up interviews with licensed staff revealed the following significant medication errors:</p> <p>On 09/20/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #2 administered 12 units of Lantus insulin and 10 units of the sliding scale Humalog insulin. Resident #14's actual blood sugar was undetermined and the amount of Humalog insulin need could not be calculated.</p> <p>On 09/21/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #5 administered 12 units of Lantus insulin and 10 units of the sliding scale Humalog insulin. Resident #14's actual blood sugar undetermined and the resident's needed dosage of Humalog insulin could not be calculated.</p>	F 333		

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F 333	<p>Continued From page 32</p> <p>On 09/22/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #5 administered 12 units of Lantus insulin and 10 units of the sliding scale Humalog insulin. Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 09/24/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #5 administered 12 units of Lantus insulin and 10 units of the sliding scale Humalog insulin. Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 09/25/10 at 5:00 AM Resident #14's accucheck was "HI". LPN #7 administered 8 units of Humalog insulin. Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 09/27/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #9 administered 12 units of Lantus insulin and 10 units of the sliding scale Humalog insulin. Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 09/28/10 at 4:00 PM, Resident #14's accucheck was 537 mg/dl. LPN #8 administered administered 12 units Lantus insulin and 7 units of Humalog insulin. In accordance with the ordered calculation, LPN #8 should have administered 14 units of Humalog insulin.</p> <p>On 09/29/10 at 4:00 PM, Resident #14's</p>	F 333			

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F 333	<p>Continued From page 33</p> <p>accucheck result was "HI". LPN #8 administered 12 units of Lantus insulin and 10 units of the sliding scale Humalog insulin. Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 09/30/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #8 administered 12 units of Lantus insulin and 10 units of the sliding scale Humalog insulin. Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 10/01/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #1 administered 12 units of Lantus insulin and 10 units of the sliding scale Humalog insulin. Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 10/04/10 at 4:00 PM, Resident #14's accucheck was 367 mg/dl. LPN #6 administered 12 units of Lantus insulin and 5 units sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #6 should have administered 8 units of Humalog insulin.</p> <p>On 10/05/10 at 4:00 PM, Resident #14's accucheck was 331 mg/dl. LPN #5 administered 12 units of Lantus insulin and no sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #5 should have administered 7 units of Humalog insulin.</p> <p>3. Review of the physician's orders on 10/06/10, revealed routine Lantus was increased to 14 units</p>	F 333			

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F 333	<p>Continued From page 34</p> <p>every day. Review of the resident's Diabetic Record from 10/06/10 through 10/28/10 and follow-up interviews with licensed staff revealed the following significant medication errors:</p> <p>On 10/06/10 at 7:00 AM, LPN #1 administered 4 units of sliding scale Humalog insulin based on Resident #14's accucheck of 227 mg/dl, which was obtained at 5:00 AM. Based on the physician's order there was no indicated need for sliding scale insulin unless the resident's blood sugar was greater than 250 mg/dl. LPN #1 should not have administered any sliding scale Humalog insulin.</p> <p>On 10/07/10 at 7:00 AM, LPN #1 administered 4 units of sliding scale Humalog insulin based on Resident #14's accucheck of 232 mg/dl, which was obtained at 5:00 AM. Based on the physician's order there was no indicated need for sliding scale insulin unless the resident's blood sugar was greater than 250 mg/dl. LPN #1 should not have administered any sliding scale Humalog insulin.</p> <p>On 10/07/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #5 administered 14 units of Lantus insulin and 10 units of the sliding scale Humalog insulin. Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 10/08/10 at 4:00 PM, Resident #14's accucheck result was 463 mg/dl. LPN #5 administered 14 units of Lantus insulin and 10 units of the sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #5 should have administered 12 units of Humalog</p>	F 333			

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F 333	Continued From page 35 insulin. On 10/09/10 at 4:00 PM, Resident #14's accucheck was 302 mg/dl. LPN #3 administered 14 units of Lantus insulin and no sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #3 should have administered 6 units of Humalog insulin. On 10/10/10 at 4:00 PM, Resident #14's accucheck was 468 mg/dl. LPN #5 administered 14 units of Lantus insulin and 10 units of sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #5 should have administered 12 units of Humalog insulin. On 10/11/10 at 4:00 PM, Resident #14's accucheck was 503 mg/dl. LPN #5 administered 14 units of Lantus insulin and 10 units of sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #5 should have administered 13 units of Humalog insulin. On 10/13/10 at 4:00 PM, Resident #14's accucheck result was 133 mg/dl. LPN #5 withheld 14 units of Lantus insulin, without consultation with the resident's physician. LPN #5 should have administered 14 units of Lantus insulin as ordered. On 10/14/10 at 5:00 AM, Resident #14's accucheck was 326 mg/dl. LPN #7 failed to administer any sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #7 should have administered 7 units of Humalog insulin. On 10/14/10 at 4:00 PM, Resident #14's accucheck was 333 mg/dl. LPN #8 administered	F 333			

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F 333	<p>Continued From page 36</p> <p>14 units of Lantus insulin and no sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #8 should have administered 7 units of Humalog insulin.</p> <p>On 10/15/10 at 4:00 PM, Resident #14's accucheck was 523 mg/dl. LPN #2 administered 14 units of Lantus insulin and no sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #2 should have administered 14 units of Humalog insulin.</p> <p>On 10/16/10 at 4:00 PM, Resident #14's accucheck was 345 mg/dl. LPN #5 administered 14 units of Lantus insulin and no sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #5 should have administered 8 units of Humalog insulin.</p> <p>On 10/17/10 at 4:00 PM, Resident #14's accucheck was 280 mg/dl. Unknown licensed staff failed to administer either the scheduled 14 units of Lantus insulin or the 6 units of sliding scale Humalog insulin, which was indicated in accordance with the ordered calculation.</p> <p>On 10/18/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #8 administered 14 units of Lantus insulin and 8 units of the sliding scale Humalog regular insulin. Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 10/19/10 at 4:00 PM, Resident #14's accucheck was 440 mg/dl. LPN #2 administered 14 units of Lantus insulin and no sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #2 should have administered 11</p>	F 333			

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F 333	<p>Continued From page 37 units of Humalog insulin.</p> <p>On 10/20/10 at 4:00 PM, Resident #14's accucheck was 491 mg/dl. LPN #5 administered 14 units of Lantus insulin and 10 units of sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #5 should have administered 13 units of Humalog insulin.</p> <p>On 10/21/10 at 5:00 AM, Resident #14's accucheck was 376 mg/dl. LPN #7 administered 7 units of sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #7 should have administered 9 units of Humalog insulin.</p> <p>On 10/21/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #5 administered 14 units of Lantus insulin and 10 units of the sliding scale Humalog regular insulin. Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 10/23/10 at 5:00 AM, Resident #14's accucheck was 333 mg/dl. LPN #7 failed to administer any sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #7 should have administered 7 units of Humalog insulin.</p> <p>On 10/23/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #4 administered 14 units of Lantus insulin and 10 units of the sliding scale Humalog insulin. Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated.</p>	F 333			

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F 333	<p>Continued From page 38</p> <p>On 10/23/10 at 10:00 PM, Resident #14's accucheck result was "HI". LPN #6 administered 10 units of the sliding scale Humalog insulin. Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 10/25/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #9 administered 14 units of Lantus insulin and 8 units of the sliding scale Humalog insulin. Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 10/28/10 at 4:00 PM, Resident #14's accucheck was 461 mg/dl. LPN #5 administered 14 units of Lantus insulin and 8 units of the sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #5 should have administered 12 units of Humalog insulin.</p> <p>4. Review of the physician's orders revealed on 10/29/10, the routine Lantus was changed from 4:00 PM to be administered at 7:00 AM and the sliding scale insulin was changed to blood sugar minus 100 divided by 40. A review of the pre-printed orders revealed sliding scale insulin was to be given for blood sugar results greater than 250 mg/dl. Review of the resident's Diabetic Record from 11/01/10 through 01/09/11 and follow-up interviews with licensed staff revealed the following significant medication errors:</p> <p>On 11/01/10 at 4:00 PM, Resident #14's accucheck was 493 mg/dl. LPN #2 administered 8 units of the sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #2</p>	F 333		

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F 333	<p>Continued From page 39</p> <p>should have administered 9 units of Humalog insulin.</p> <p>On 11/03/10, Resident #14's accucheck was 161 mg/dl at 6:00 AM. LPN #1 failed to administer Resident #14's scheduled dose of 14 units Lantus insulin at 7:00 AM as ordered. LPN #1 administered the 14 units of Lantus insulin at 11:00 AM.</p> <p>On 11/03/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #5 administered 10 units of the sliding scale Humalog insulin. Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 11/04/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #5 administered 10 units of the sliding scale Humalog insulin. Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 11/05/10 at 5:00 AM, Resident #14's accucheck was 414 mg/dl. LPN #7 administered 5 units of the sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #7 should have administered 7 units of Humalog insulin.</p> <p>On 11/08/10 at 5:00 AM, Resident #14's accucheck was 280 mg/dl. LPN #6 failed to administer any sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #6 should have administered 4 units of Humalog insulin.</p> <p>On 11/08/10 at 4:00 PM, Resident #14's</p>	F 333			

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F 333	<p>Continued From page 40</p> <p>accucheck result was "HI". LPN #5 administered 10 units of the sliding scale Humalog regular insulin. Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 11/09/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #5 administered 10 units of the sliding scale Humalog regular insulin. Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 11/10/10 at 4:00 PM, Resident #14's accucheck was 502 mg/dl. LPN #5 administered 14 units of Lantus insulin and 7 units of sliding scale Humalog insulin. LPN #5 should not have administered the 14 units of Lantus as the time of administration had been changed to 7:00 AM on 10/29/10. In accordance with the ordered calculation, LPN #5 should have administered 10 units of Humalog insulin.</p> <p>On 11/11/10 at 7:00 AM, Resident #14's accucheck result was 137 mg/dl. LPN #1 withheld the Lantus insulin, without consulting with the resident's physician. LPN #1 should have administered 14 units of Lantus insulin as ordered.</p> <p>On 11/12/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #6 administered 10 units of the sliding scale Humalog regular insulin. Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 11/13/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #5 administered</p>	F 333			

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F 333	<p>Continued From page 41</p> <p>10 units of the sliding scale Humalog regular insulin. Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 11/14/10 at 5:00 AM, Resident #14's accucheck was 302 mg/dl. LPN #6 failed to administer any sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #6 should have administered 5 units of Humalog insulin.</p> <p>On 11/14/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #5 administered 10 units of the sliding scale Humalog insulin. Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 11/15/10 at 12:00 AM, Resident #14's accucheck result was "HI". LPN #6 administered 10 units of the sliding scale Humalog insulin. Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 11/15/10 5:00 AM, Resident #14's accucheck was "HI". LPN #6 failed to administer the sliding scale Humalog insulin. Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 11/15/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #2 administered 10 units of the sliding scale Humalog insulin. Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated.</p>	F 333			

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F 333	Continued From page 42 On 11/16/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #5 administered 10 units of the sliding scale Humalog insulin. Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated. On 11/17/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #5 administered 10 units of the sliding scale Humalog regular insulin. Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated. On 11/19/10 at 5:00 AM, Resident #14's accucheck was 268 mg/dl. LPN #7 failed to administer any sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #7 should have administered 4 units of Humalog insulin. On 11/21/10 at 5:00 AM, Resident #14's accucheck was 326 mg/dl. LPN #6 failed to administer any sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #6 should have administered 5 units of Humalog insulin. On 11/22/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #5 administered 10 units of the sliding scale Humalog regular insulin. Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated. On 11/24/10 at 4:00 AM, Resident #14's accucheck was 274 mg/dl. LPN #5 failed to administer any sliding scale Humalog insulin. In	F 333			

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F 333	<p>Continued From page 43</p> <p>accordance with the ordered calculation, LPN #5 should have administered 4 units of Humalog insulin.</p> <p>On 11/26/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #2 administered 10 units of the sliding scale Humalog insulin. Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 11/27/10 at 5:00 AM, Resident #14's accucheck result was "HI". LPN #7 administered 8 units of the sliding scale Humalog insulin. Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 11/27/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #5 administered 10 units of sliding scale Humalog regular insulin. Resident #14's blood sugar could not be determined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 11/29/10 at 4:00 PM, Resident #14's accucheck result was 367 mg/dl. LPN #5 administered 5 units of sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #5 should have administered 6 units of Humalog insulin.</p> <p>On 12/01/10 at 4:00 PM, Resident #14's accucheck was 256 mg/dl. LPN #5 did not administer sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #5 should have administered 3 units of Humalog insulin.</p>	F 333			

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F 333	<p>Continued From page 44</p> <p>On 12/10/10 at 5:00 AM, Resident #14's accucheck was 361 mg/dl. LPN #7 did not administer sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #7 should have administered 6 units of Humalog insulin.</p> <p>On 12/12/10 at 4:00 PM, Resident #14's accucheck was 509 mg/dl. LPN #7 administered 5 units of sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #5 should have administered 10 units of Humalog insulin.</p> <p>On 12/13/10 at 4:00 PM, Resident #14's accucheck was 411 mg/dl. LPN #9 administered 4 units of sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #9 should have administered 7 units of Humalog insulin.</p> <p>On 12/14/10 at 4:00 PM, Resident #14's accucheck was 476 mg/dl. LPN #2 administered 5 units of sliding scale Humalog insulin per nursing judgment. In accordance with the ordered calculation, LPN #2 should have administered 9 units of Humalog insulin.</p> <p>On 12/15/10 at 4:00 PM, Resident #14's accucheck was 377 mg/dl. LPN #2 administered 5 units of sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #2 should have administered 6 units of Humalog insulin.</p> <p>On 12/16/10 at 4:00 PM, Resident #14's accucheck was 383 mg/dl. LPN #2 administered 5 units of sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #2</p>	F 333			

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F 333	<p>Continued From page 45</p> <p>should have administered 7 units of Humalog insulin.</p> <p>On 12/17/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #2 administered 10 units of sliding scale Humalog regular insulin. Resident #14's blood sugar could not be determined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 12/19/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #4 administered 10 units of sliding scale Humalog regular insulin. Resident #14's blood sugar could not be determined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 12/20/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #1 administered 10 units of sliding scale Humalog regular insulin. Resident #14's blood sugar could not be determined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 12/21/10 at 5:00 AM, Resident #14's accucheck result was 270 mg/dl. LPN #15 did not administer sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #15 should have administered 4 units of Humalog insulin.</p> <p>On 12/22/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #1 administered 10 units of sliding scale Humalog regular insulin. Resident #14's blood sugar could not be determined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 12/23/10 at 5:00 AM, Resident #14's</p>	F 333			

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F 333	<p>Continued From page 46</p> <p>accucheck result was "HI". LPN #7 administered 7 units of sliding scale Humalog insulin. Resident #14's blood sugar could not be determined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 12/23/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #2 administered 10 units of sliding scale Humalog insulin. Resident #14's blood sugar could not be determined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 12/23/10 at 8:00 PM, Resident #14's accucheck result was "HI". LPN #7 administered 5 units of sliding scale Humalog insulin. Resident #14's blood sugar could not be determined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 12/24/10 at 5:00 AM, Resident #14's accucheck result was 377 mg/dl, LPN#7 did not administer sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #7 should have administered 6 units of Humalog insulin.</p> <p>On 12/24/10 at 4:00 PM, Resident #14's accucheck result was "HI". An unidentified LPN administered 10 units of sliding scale Humalog regular insulin. Resident #14's blood sugar could not be determined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 12/25/10 at 12:00 AM, Resident #14's accucheck result was "HI". LPN #7 administered 5 units of sliding scale Humalog insulin. Resident #14's blood sugar could not be determined and</p>	F 333			

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F 333	<p>Continued From page 47</p> <p>the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 12/25/10 at 5:00 AM, Resident #14's accucheck result was 344 mg/dl. LPN #7 did not administer sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #7 should have administered 6 units of Humalog insulin.</p> <p>On 12/27/10 at 6:00 AM, Resident #14's accucheck result was 211 mg/dl LPN #1 administered 10 units of Lantus insulin. LPN #1 should have administered 14 units of Lantus insulin as ordered.</p> <p>On 12/27/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #2 administered 10 units of sliding scale Humalog insulin. Resident #14's blood sugar could not be determined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 12/27/10 at 8:00 PM, Resident #14's accucheck result was "HI". LPN #2 administered 5 units of sliding scale Humalog insulin. Resident #14's blood sugar could not be determined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 12/28/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #5 administered 10 units of sliding scale Humalog insulin. Resident #14's blood sugar could not be determined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 12/29/10 at 4:00 PM, Resident #14's accucheck result was 258 mg/dl. LPN #5 did not</p>	F 333			

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F 333	<p>Continued From page 48</p> <p>administer sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #5 should have administered 3 units of Humalog insulin.</p> <p>On 12/31/10 at 10:00 PM, Resident #14's accucheck result was 494 mg/dl. LPN #2 administered 5 units of sliding scale Humalog insulin. In accordance with ordered calculation, LPN #2 should have administered 9 units of Humalog insulin.</p> <p>On 01/01/11 at 11:00 AM, Resident #14's accucheck result was "HI". LPN #1 administered 10 units of sliding scale Humalog insulin. Resident #14's blood sugar could not be determined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 01/01/11 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #4 administered 10 units of sliding scale Humalog insulin. Resident #14's blood sugar could not be determined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 01/02/11 at 11:30 AM, Resident #14's accucheck result was "HI". LPN #1 administered 10 units of sliding scale Humalog regular insulin. Resident #14's blood sugar could not be determined and the resident's needed dosage of Humalog insulin could not be calculated.</p> <p>On 01/08/11 at 8:00 PM, Resident #14's accucheck result was 362 mg/dl. LPN #6 did not administer sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #6 should have administered 6 units of Humalog insulin.</p>	F 333			

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F 333	<p>Continued From page 49</p> <p>On 01/09/11 at 12:00 AM, Resident #14's accucheck result was 269 mg/dl. LPN #6 did not administer sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #6 should have administered 6 units of Humalog insulin.</p> <p>Interview with the Director of Nursing (DON), on 02/25/11 at 5:00 PM and on 03/08/11 at 1:05 PM, revealed she expected the licensed staff to notify the physician for direction whenever there was a "HI" glucometer reading because there would be no blood sugar level to use to calculate the administration of sliding scale insulin. She stated the nurse should never alter any dose of medication based on nursing judgement and if the licensed staff had a concern regarding the administration of any medication she would expect the staff to notify the physician of their concern and seek direction for the medication administration. The DON revealed it would be outside the nurse's scope of practice to alter any dose of medication based solely on their judgement.</p> <p>Interview with Resident #14's attending physician, on 02/25/11 at 5:50 PM and on 03/08/11 at 1:30 PM, revealed he expected the licensed staff to notify the physician when there was a "HI" glucometer reading and he was unaware the licensed staff had routinely altered the dose of insulin administered for Resident #14. He revealed the staff should have notified him or the physician on-call anytime there was a concern with the administration of any medication and never base administration on nursing judgement without contacting a licensed physician for direction.</p>	F 333			

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F 333	Continued From page 50 An acceptable Allegation of Compliance (AoC) was received on 03/16/11 and detailed as follows: Criteria #1: Resident #14 no longer resides at the facility. An audit was completed by the Assistant Director of Nursing (ADON) of the diabetes management interventions documented for Resident #14, with investigation of the circumstances in which insulin administration was not consistent with the MD (physician) orders. The facility disciplinary action policy was has been implemented for the licensed nursing staff identified to have insulin administration inconsistent with MD orders, in the form of a final written warning with further non-compliance to result in disciplinary action up to and including termination. Criteria #2: An audit has been completed by the ADON on 03/09/11 of the facility residents with the diagnosis of diabetes requiring insulin administration the last 90 days to determine that glucose finger stick results have been obtained, documented and reported with accurate insulin dosage administration as indicated. Addendum to the audit was made on 03/15/11 by the ADON identifying the error of administering sliding scale insulin without having an actual glucose reading, instead basing the calculation on a reading of "HIGH." The DON and Administrator reviewed these findings. All identified discrepancies involving inaccurate insulin dosage administration were identified as significant medication errors and were reviewed with and acknowledged by the attending physician to discuss the residents current status and review current insulin orders. No new physician orders were indicated or determined by the physicians. MD orders for	F 333			

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F 333	<p>Continued From page 51</p> <p>parameters for reporting of high and low glucose levels were obtained for residents receiving insulin injections. The hyperglycemia policy was provided and acknowledged by the facility attending physicians and Medical Director.</p> <p>Criteria #3: The facility policy/procedure for Diabetes Management, including management of hyperglycemia was reviewed/ revised to address the following:</p> <p>A. Obtaining, interpreting, and reporting of glucose finger sticks in accordance with physician orders and physician ordered result parameters.</p> <p>B. Assessment of the resident with abnormal glucose finger stick results, with documentation and reporting of the findings.</p> <p>C. Administration of insulin in accordance with physician orders to avoid significant medication errors.</p> <p>The facility has implemented a new Diabetic Record to be used for the documentation of glucose finger stick results, insulin dosage orders, and administration. The DON received in-service education as provided by the nursing consultant by telephone conversations on 03/08/11 and 03/09/11, prior to the in-service for the licensed staff on the following:</p> <p>A. The F-157 regulatory requirements for physician notification, including notification of the MD for finger stick glucose results in accordance with MD ordered parameters, and MD notification of assessment findings related to resident change in status, especially as associated with hyperglycemia.</p>	F 333			

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F 333	<p>Continued From page 52</p> <p>B. Administration of insulin in accordance with MD orders, and the need to notify the physician if the residents status denotes that insulin order changes may be indicated.</p> <p>C. Review of the facility Diabetes Management Policies and Procedures and revisions, including the new Diabetic Record; physician ordered parameters for the reporting of glucose finger stick results; the calculation of sliding scale insulin dosage in accordance with MD orders; and the administration of insulin in accordance with physician orders.</p> <p>D. The protocol for two nurses to verify and initial routine and sliding scale insulin doses administered to residents. The DON received in-service education as provided by the nursing consultant on 03/15/11, prior to the in-service for the licensed nursing staff on the following:</p> <p>A. Revisions to the Diabetic Management-Hyperglycemia policy.</p> <p>B. Administration of insulin in accordance with MD orders, and the need to notify the physician if the resident's status denotes that insulin order changes may be indicated.</p> <p>Utilizing the employee listing, licensed nursing staff have received in-service education provided by the DON on 03/09/11, on 03/15/11 and on 03/16/11 regarding Diabetes Management interventions, including but not limited to the following:</p> <p>A. The F-157 regulatory requirements for physician notification, including notification of the</p>	F 333		

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F 333	<p>Continued From page 53</p> <p>MD for finger stick glucose results in accordance with MD ordered parameters, and MD notification of assessment findings related to resident change in status, especially as associated with hyperglycemia.</p> <p>B. Administration of insulin in accordance with MD orders to prevent a significant medication error, and the need to notify the physician if the residents status denotes that insulin order changes may be indicated.</p> <p>C. Review of the facility Diabetes Management Policies and Procedures and revisions, including the new Diabetic Record; physician ordered parameters for the reporting of glucose finger stick results; the calculation of sliding scale insulin dosage in accordance with MD orders; and the administration of insulin in accordance with physician orders.</p> <p>D. The protocol for two nurses to verify and initial routine and sliding scale insulin doses administered to residents. Licensed nursing staff were administered a written medication administration test which included questions pertaining to insulin, as provided by the DON on 03/09/11, on 03/15/11 and on 03/16/11. Licensed nurses will be provided the in-service information referenced above as part of the facility orientation process, and will have completion of the Diabetes Management Skills Checklist as provided by the DON or designee. The Administrator has reviewed all in-service information and verified attendance of licensed nursing staff on 03/17/11.</p> <p>Criteria #4: Two (2) licensed nursing staff will verify and initial routine and sliding scale insulin doses administered to residents. The CQI</p>	F 333			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185341	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/18/2011
NAME OF PROVIDER OR SUPPLIER GREEN ACRES HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 402 W. FARTHING STREET MAYFIELD, KY 42066		
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F 333	<p>Continued From page 54</p> <p>indicator for the monitoring of compliance with the facility policy/procedure and MD orders for Diabetes Management will be utilized monthly X 2 months, and then quarterly thereafter under the supervision of the DON. The Administrator will review the completed CQI indicator to determine compliance and to determine if an action plan is indicated for any identified issues. The DON and/or Nurse Consultant will review all facility Diabetic Records weekly X 1 month, and then five chosen randomly on a monthly basis thereafter to determine compliance with the facility policies/procedures and MD orders. The CQI indicator for the monitoring of the effectiveness of the QA process will be utilized monthly X 2 months and then quarterly under the supervision of the Administrator. The Corporate Consultant will review the completed CQI indicator to determine if an action plan is indicated for any identified issues. A Diabetes Management skills check list is being completed on two licensed nursing staff daily for two weeks, and then weekly for four weeks, and then monthly for three months, and then quarterly thereafter by the DON/Pharmacy Consultant/Administrative Nursing/Nursing Consultant during observations of finger stick glucose testing and insulin preparation/administration to determine compliance with these procedures and accurate insulin administration.</p> <p>Criteria #5: March 17, 2011.</p> <p>During the extended survey, on 03/16/11 through 03/18/11, verification of the removal of Immediate Jeopardy was completed as follows:</p> <p>Interviews with Registered Nurse (RN) #1, RN #2, RN #3, LPN #8, LPN #9, LPN #10, LPN #11, LPN</p>	F 333			

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F 333	<p>Continued From page 55</p> <p>#12 and LPN #13, on 03/17/11 at 2:25 PM, on 03/18/11 at 9:00 AM, on 03/17/11 at 11:35 AM, on 03/17/11 at 2:17 PM, on 03/18/11 at 9:30 AM, on 03/17/11 at 1:55 PM, on 03/17/11 at 10 :35 AM, on 03/17/11 at 3:00 PM and on 03/17/11 at 1:50 PM respectively, revealed the licensed staff were educated regarding notification of the physician for finger stick glucose results in accordance with physician ordered parameters, physician notification of assessment findings related to resident change in status, administration of insulin in accordance with physician orders to prevent a significant medication error; the need to notify the physician if the residents status denotes that insulin order changes may be indicated; physician ordered parameters for the reporting of glucose finger stick results; the calculation of sliding scale insulin dosage in accordance with physician orders; and the protocol for two nurses to verify and initial routine and sliding scale insulin doses administered to residents. The interviews revealed the staff understood the content of the inservice and individual responsibility.</p> <p>Observations of RN #1, LPN #11 and LPN #13, on 03/17/11 between 11:00 AM and 11:45 AM, revealed staff obtained accuchecks on five residents and administered insulin to four residents. Insulin doses were verified by two licensed staff as directed by the AoC. Both routine insulin and sliding scale insulin was administered in accordance with the written physician order.</p> <p>A record review, on 03/17/11 at 10:30 AM, revealed the facility had initiated Diabetic Management check lists for all licensed nursing staff on 03/11/11 and had completed 16 competency checks at the time of review with the</p>	F 333			

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F 333	<p>Continued From page 56</p> <p>process continuing until all licensed nursing staff had been checked off.</p> <p>A record review, on 03/17/11 at 10:35 AM, revealed all licensed nursing staff had completed a written test on medication administration and review of the test revealed questions pertained to Diabetes, insulin and insulin administration including questions requiring the staff to calculate sliding scale insulin doses.</p> <p>A review of all residents records with the diagnosis of Diabetes who also received either sliding scale insulin or routine insulin, on 03/17/11 at 11:50 AM, revealed all residents had the new Diabetic Record in place with physician established parameters for physician notification regarding both high and low blood sugar levels. Record review also revealed four residents with the diagnosis of Diabetes, who only had accuchecks ordered but did not have orders for insulin, had the new Diabetic Record in place with established parameters for physician notification regarding abnormal blood sugar levels.</p> <p>A review of the facility's audit of other residents with the potential to be affected by the deficient practice revealed the facility identified other residents affected by the practice and notified the physician of each resident affected by the deficient practice.</p> <p>A review of sign-in sheets for all in-services the facility provided in response to the Immediate Jeopardy revealed all licensed staff had attended the training sessions except one staff member who was hospitalized.</p> <p>An interview with the DON, on 03/17/11 at 2:00</p>	F 333			

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F 333	Continued From page 57 PM, revealed the DON would monitor the Continuous Quality Improvement (CQI) by auditing all diabetic records weekly for one month and then five chosen randomly on a monthly basis thereafter to determine compliance with the facility policy/procedure and physician orders. The DON stated the audit would include whether the resident had Diabetes identified through the care plan process, monitoring of the diabetic record to ensure accuracy and completion, parameters for hypoglycemia and hyperglycemia were listed on both the Diabetic Record and the physician orders and documentation of evening snacks provided to Diabetic residents. She stated all hypo and hyperglycemic events would be reviewed to ensure all protocols were followed. The DON stated if audits do not demonstrate at least 95 percent compliance, an action plan would be developed immediately to address any identified problems. An interview with the Administrator, on 03/18/11 at 11:15 AM, revealed he would be completing a check list after reviewing audits completed by the DON to ensure policy and procedure was followed correctly and if any problem were to be identified regarding audits not being completed as directed by the AoC, he would initiate disciplinary action. Based on the above observations, interviews and review of records, it was determined the Immediate Jeopardy was removed, effective 03/17/11, as alleged in the AoC with the scope and severity lowered to an "E", based on the need to continue to evaluate the implementation of changes and quality assurance activities.	F 333			
F 520 SS=K	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET	F 520			

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F 520	<p>Continued From page 58</p> <p>QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>/</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to ensure the quality assessment and assurance committee was effective in identifying and correcting quality of care issues related to the inappropriate administration of insulin for one resident (#14) in the selected sample of 15. The facility failed to ensure policy and procedures related to medication administration were followed and resident's were free from significant medication</p>	F 520	<p>483.75(o)(1) QAA COMMITTEE - MEMBERS/MEET/QUARTERLY/PLANS</p> <p>The facility shall maintain a quality assessment and assurance committee consisting of (i) the director of nursing services; (ii) a physician designated by the facility; and (iii) at least 3 other members of the facility's staff. (2) The quality assessment and assurance committee (i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and (ii) develops and implements appropriate plans of action to correct identified quality deficiencies. (3) A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. (4) Good faith attempts by the committee to identify and correct deficiencies will not be used as a basis for sanctions:</p> <p>Criteria 1:</p> <ul style="list-style-type: none"> Resident #14 no longer resides at the facility. An audit has been completed by the ADON of the Diabetes Management 		

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F 520	<p>Continued From page 59</p> <p>errors. Resident #14 had multiple diagnoses which include Diabetes (uncontrolled blood sugar) and the physician had ordered routine insulin and sliding scale insulin administration (dosage of insulin is adjusted based on the resident's blood sugar level) to control the resident's blood sugar. Record review revealed from 09/01/10 through 01/13/11, the facility's licensed nurses failed to administer or hold (did not administer) insulin medication to Resident #14 in accordance to the physician's order a total of one hundred and ten (110) times. The documentation revealed the licensed nursing staff withheld the resident's routine scheduled insulin (non sliding scale) six (6) times; withheld sliding scale insulin despite the physician's order to administer the insulin based on the resident's elevated blood sugar level twenty-four (24) times; and, altered the dosage of sliding scale insulin that was not in accordance with the physician order for sliding scale insulin eighty (80) times. As a result of the facility practice, Resident #14 was at risk for severe hyperglycemic and hypoglycemic episodes. The facility's failure to identify the improper administration of insulin resulted in a situation that was likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified and the facility was notified, on 03/08/11.</p> <p>The findings include:</p> <p>A review of the facility policy entitled, Quality Assurance Program, with an effective date of January 1996 and a revision date of May 2004, revealed the facility's Quality Assurance Program was a comprehensive program designed to monitor all departments and the physical plant in order to identify areas in which there are</p>	F 520	<p>interventions documented for resident #14, with investigation of the circumstances identified in which insulin administration was not consistent with the MD orders. The facility disciplinary action policy has been implemented for the licensed nursing staff identified to have insulin administration inconsistent with MD orders, in the form of a final written warning with further non-compliance to result in disciplinary action up to and including termination.</p> <p>Criteria 2:</p> <ul style="list-style-type: none"> An audit has been completed by the ADON on 3-9-11 of facility residents with the diagnosis of diabetes requiring insulin administration for the last 90 days to determine that glucose finger stick results have been obtained, documented and reported with accurate insulin dosage administration as indicated. Addendum to the audit was made on 3/15/11 by the ADON identifying the error of administering sliding scale insulin without having an actual glucose reading, instead basing the calculation on a reading of 'HIGH'. The DON and Administrator have reviewed these findings. All identified discrepancies involving inaccurate insulin dosage administration were identified as significant medication errors and were reviewed with and acknowledged by the attending physicians to discuss the resident's current status and review current insulin orders. No new physician orders were indicated or determined by the physicians. MD orders for parameters for the reporting of low and high glucose levels have been obtained for residents receiving insulin injections. The hyperglycemia policy was provided and 		

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F 520	<p>Continued From page 60</p> <p>problems or opportunities for improvement. The Executive Quality Assurance Committee is responsible for the implementation of the program through development of appropriate plans of action that support and encourage quality care and correct identified quality deficiencies. The Policy further states that the Director of Nursing is the Quality Assurance Coordinator.</p> <p>The facility admitted Resident #14, on 01/10/08, with diagnoses to include Diabetes Mellitus and Chronic Renal Failure. Review of Diabetic Records for the months of September 2010, October 2010, November 2010, December 2010 and January 2011 revealed on 110 occasions licensed nursing staff altered the amount of sliding scale insulin administered, withheld both routine insulin and sliding scale insulin, administered sliding scale insulin of various amounts without a valid blood sugar result needed to calculate the dosage of insulin, altered the dosage and time of administration of the routine Lantus insulin all of which was not in accordance with the physician's orders for Resident #14. The documentation revealed the licensed nursing staff withheld the resident's routine scheduled insulin (non sliding scale) six (6) times; withheld sliding scale insulin despite the physician's order to administer the insulin based on the resident's elevated blood sugar level twenty-four (24) times; and, altered the dosage of sliding scale insulin that was not in accordance with the physician order for sliding scale insulin eighty (80) times. Review of the Resident #14's medical record revealed no documented evidence that the licensed nurses notified the physician when a need to alter treatment was indicated. Additionally, there was no documented evidence that the charge nurse made two</p>	F 520	<p>acknowledged by the facility attending physicians and Medical Director.</p> <p>Criteria 3:</p> <ul style="list-style-type: none"> The facility policy/procedure for Diabetes Management, including management of hyperglycemia has been reviewed/ revised to address the following: (a) Obtaining, interpreting, and reporting of glucose finger stick results in accordance with physician orders and physician ordered result parameters; (b) Assessment of the resident with abnormal glucose finger stick results, with documentation and reporting of the findings; and (c) Administration of insulin in accordance with physician orders to avoid significant medication errors. The facility has implemented a new Diabetic Record to be used for the documentation of glucose finger stick results, insulin dosage orders, and administration. The Director of Nursing received in-service education as provided by the Nursing Consultants by telephone conversations on 3/8 and 3/9/11 and in person on 3/15/11 prior to the in-service for the licensed nursing staff on the following: (a) The F 157 regulatory requirements for physician notification, including notification of the MD for finger stick glucose results in accordance with MD ordered parameters, and MD notification of assessment findings r/t resident change in status, especially as associated with hyperglycemia; (b) Administration of insulin in accordance with MD orders, and the need to notify the physician if the residents' status denotes that insulin order changes may be indicated; (c) Review of the facility Diabetes Management Policies and 		

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F 520	<p>Continued From page 61</p> <p>attempts to notify the attending physician within a ten minute period and when unsuccessful, notified the physician on call or the Medical Director regarding the need to alter Resident #14's diabetic treatment. (Refer to F333 for Resident #14's physician orders related to diabetic management and for specific detail of dates of the facility administering diabetic medications not in accordance with the physician's orders)</p> <p>The facility could provide no evidence that their Quality Assurance program had identified or implemented a plan of correction related to their licensed nursing staff routinely altering Resident #14's diabetic treatment without notifying the physician (attending/on call/medical director).</p> <p>Interviews with the Director of Nursing (DON) designated as the Quality Assurance Coordinator, on 02/25/11 at 5:00 PM and on 03/08/11 at 1:05 PM, revealed the nurse should never alter any dose of medication based on nursing judgement, and if the licensed staff had a concern regarding the administration of any medication she would expect the staff to notify the physician of their concern and seek direction for administration. She further revealed that had never identified this practice occurring in this facility.</p> <p>An interview with the facility's former administrator (04/01/02 through 01/28/11), on 03/18/11 at 9:20 AM, revealed the Continuous Quality Improvement (CQI) committee met at least quarterly to discuss identified problems or concerns and develop action plans to address any identified areas. She stated she was unaware the licensed nursing staff was not administering insulin in accordance with written</p>	F 520	<p>Procedures and revisions, including the new Diabetic Record; physician ordered parameters for the reporting of glucose finger stick results; the calculation of sliding scale insulin dosage in accordance with MD orders; and the administration of insulin in accordance with physician orders; and (d) The protocol for 2 nurses to verify and initial routine and sliding scale insulin doses administered to residents.</p> <ul style="list-style-type: none"> Utilizing the employee listing, licensed nursing staff have received in-service education provided by the DON on 3/9/11, 3/15/11 and 3/16/11 regarding Diabetes Management interventions, including but not limited to the following: (a) The F 157 regulatory requirements for physician notification, including notification of the MD for finger stick glucose results in accordance with MD ordered parameters, and MD notification of assessment findings r/t resident change in status, especially as associated with hyperglycemia; (b) Administration of insulin in accordance with MD orders to prevent a significant medication error, and the need to notify the physician if the residents' status denotes that insulin order changes may be indicated; (c) Review of the facility Diabetes Management Policies and Procedures and revisions, including the new Diabetic Record; physician ordered parameters for the reporting of glucose finger stick results; the calculation of sliding scale insulin dosage in accordance with MD orders; and the administration of insulin in accordance with physician orders; and (d) The protocol for 2 nurses to verify and initial routine and sliding scale insulin doses administered to residents. 	

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F 520	<p>Continued From page 62</p> <p>physician's orders, but felt it was a problem she should have been aware of through the CQI process.</p> <p>An interview with the facility Medical Director, on 03/18/11 at 10:25 AM, revealed the CQI committee met at least quarterly and more often as needed. He stated the CQI process should, hopefully, identify an issue such as improper insulin administration but he was unaware of the problem until identified through the survey process.</p> <p>An interview with the facility's current administrator and the facility owner, on 03/18/11 at 11:15 AM, revealed care issues were identified through the CQI process by review of quality indicators, review of audits completed for each department, concerns brought to managements attention from either staff members, residents or resident's families and from rounds conducted to observe care. While the facility identifies quality concerns through these methods, they could not provide evidence that their CQI process had identified these failures in improper insulin administration.</p> <p>An acceptable Allegation of Compliance (AoC) was received on 03/16/11 and detailed as follows:</p> <p>Criteria #1: Resident #14 no longer resides at the facility. An audit was completed by the Assistant Director of Nursing (ADON) of the diabetes management interventions documented for Resident #14, with investigation of the circumstances in which insulin administration was not consistent with the MD (physician) orders. The facility disciplinary action policy was has been implemented for the licensed nursing staff</p>	F 520	<ul style="list-style-type: none"> • Licensed nursing staff were administered a written medication administration test which included questions pertaining to insulin, as provided by the DON on 3/9/11, 3/15/11 and 3/16/11. • Licensed nurses will be provided the in-service information referenced above as part of the facility orientation process, and will have completion of the Diabetes Management Skills Check list as provided by the DON or designee. • The Administrator has reviewed all in-service information and verified attendance of licensed nursing staff on 3/16/11. • As chairperson of the QA Committee, the Administrator shall delegate and supervise the implementation and evaluation of these corrective actions to ensure that the facility is in compliance with State and Federal regulations regarding resident rights, quality of care, resident assessment and administration. <p>Criteria 4:</p> <ul style="list-style-type: none"> • Two (2) licensed nursing staff will verify and initial routine and sliding scale Insulln doses administered to residents. • The CQI indicator for the monitoring of compliance with the facility policy/procedure and MD orders for Diabetes Management will be utilized monthly X 2 months, and then quarterly thereafter under the supervision of the DON. The Administrator will review the completed CQI Indicator to determine compliance and to determine if an action plan is indicated for any identified issues. • The DON and/or Nurse consultant will review all facility Diabetic Records weekly X 1 month, and then 5 chosen randomly on a monthly basis thereafter to determine 		

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F 520	<p>Continued From page 63</p> <p>identified to have insulin administration inconsistent with MD orders, in the form of a final written warning with further non-compliance to result in disciplinary action up to and including termination.</p> <p>Criteria #2: An audit has been completed by the ADON on 03/09/11 of the facility residents with the diagnosis of diabetes requiring insulin administration the last 90 days to determine that glucose finger stick results have been obtained, documented and reported with accurate insulin dosage administration as indicated. Addendum to the audit was made on 03/15/11 by the ADON identifying the error of administering sliding scale insulin without having an actual glucose reading, instead basing the calculation on a reading of "HIGH." The DON and Administrator reviewed these findings. All identified discrepancies involving inaccurate insulin dosage administration were identified as significant medication errors and were reviewed with and acknowledged by the attending physician to discuss the residents current status and review current insulin orders. No new physician orders were indicated or determined by the physicians. MD orders for parameters for reporting of high and low glucose levels were obtained for residents receiving insulin injections. The hyperglycemia policy was provided and acknowledged by the facility attending physicians and Medical Director.</p> <p>Criteria #3: The facility policy/procedure for Diabetes Management, including management of hyperglycemia was reviewed/revised to address the following:</p> <p>A. Obtaining, interpreting, and reporting of glucose finger sticks in accordance with physician</p>	F 520	<p>compliance with the facility policies/procedures and MD orders.</p> <ul style="list-style-type: none"> The CQI indicator for the monitoring of the effectiveness of the QA process will be utilized monthly X 2 months and then quarterly under the supervision of the Administrator. The Corporate Consultant will review the completed CQI indicator to determine if an action plan is indicated for any identified issues. A Diabetes Management skills check list is being completed on 2 licensed nursing staff daily for 2 weeks, then weekly for 4 weeks, and then monthly for 3 months and then quarterly thereafter by the DON/Pharmacy Consultant/Administrative Nursing/Nursing Consultant during observations of finger stick glucose testing and insulin preparation administration to determine compliance with these procedures and accurate insulin medication administration. <p>Criteria 5:</p>	03/19/11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185341	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/18/2011
NAME OF PROVIDER OR SUPPLIER GREEN ACRES HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 402 W. FARTHING STREET MAYFIELD, KY 42066		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 520	<p>Continued From page 64</p> <p>orders and physician ordered result parameters.</p> <p>B. Assessment of the resident with abnormal glucose finger stick results, with documentation and reporting of the findings.</p> <p>C. Administration of insulin in accordance with physician orders to avoid significant medication errors.</p> <p>The facility has implemented a new Diabetic Record to be used for the documentation of glucose finger stick results, insulin dosage orders, and administration. The DON received in-service education as provided by the nursing consultant by telephone conversations on 03/08/11 and 03/09/11, prior to the in-service for the licensed staff on the following:</p> <p>A. The F-157 regulatory requirements for physician notification, including notification of the MD for finger stick glucose results in accordance with MD ordered parameters, and MD notification of assessment findings related to resident change in status, especially as associated with hyperglycemia.</p> <p>B. Administration of insulin in accordance with MD orders, and the need to notify the physician if the residents status denotes that insulin order changes may be indicated.</p> <p>C. Review of the facility Diabetes Management Policies and Procedures and revisions, including the new Diabetic Record; physician ordered parameters for the reporting of glucose finger stick results; the calculation of sliding scale insulin dosage in accordance with MD orders; and the administration of insulin in accordance with</p>	F 520			

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F 520	<p>Continued From page 65 physician orders.</p> <p>D. The protocol for two nurses to verify and initial routine and sliding scale insulin doses administered to residents. The DON received in-service education as provided by the nursing consultant on 03/15/11, prior to the in-service for the licensed nursing staff on the following:</p> <p>A. Revisions to the Diabetic Management-Hyperglycemia policy.</p> <p>B. Administration of insulin in accordance with MD orders, and the need to notify the physician if the resident's status denotes that insulin order changes may be indicated.</p> <p>Utilizing the employee listing, licensed nursing staff have received in-service education provided by the DON on 03/09/11, on 03/15/11 and on 03/16/11 regarding Diabetes Management interventions, including but not limited to the following:</p> <p>A. The F-157 regulatory requirements for physician notification, including notification of the MD for finger stick glucose results in accordance with MD ordered parameters, and MD notification of assessment findings related to resident change in status, especially as associated with hyperglycemia.</p> <p>B. Administration of insulin in accordance with MD orders to prevent a significant medication error, and the need to notify the physician if the residents status denotes that insulin order changes may be indicated.</p> <p>C. Review of the facility Diabetes Management</p>	F 520			

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NAME OF PROVIDER OR SUPPLIER GREEN ACRES HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 402 W. FARTHING STREET MAYFIELD, KY 42066		
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F 520	<p>Continued From page 66</p> <p>Policies and Procedures and revisions, including the new Diabetic Record; physician ordered parameters for the reporting of glucose finger stick results; the calculation of sliding scale insulin dosage in accordance with MD orders; and the administration of insulin in accordance with physician orders.</p> <p>D. The protocol for two nurses to verify and initial routine and sliding scale insulin doses administered to residents. Licensed nursing staff were administered a written medication administration test which included questions pertaining to insulin, as provided by the DON on 03/09/11, on 03/15/11 and on 03/16/11. Licensed nurses will be provided the in-service information referenced above as part of the facility orientation process, and will have completion of the Diabetes Management Skills Checklist as provided by the DON or designee. The Administrator has reviewed all in-service information and verified attendance of licensed nursing staff on 03/17/11.</p> <p>Criteria #4: Two (2) licensed nursing staff will verify and initial routine and sliding scale insulin doses administered to residents. The CQI indicator for the monitoring of compliance with the facility policy/procedure and MD orders for Diabetes Management will be utilized monthly X 2 months, and then quarterly thereafter under the supervision of the DON. The Administrator will review the completed CQI indicator to determine compliance and to determine if an action plan is indicated for any identified issues. The DON and/or Nurse Consultant will review all facility Diabetic Records weekly X 1 month, and then five chosen randomly on a monthly basis thereafter to determine compliance with the facility policies/procedures and MD orders. The CQI</p>	F 520		

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NAME OF PROVIDER OR SUPPLIER GREEN ACRES HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 402 W. FARTHING STREET MAYFIELD, KY 42066		
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F 520	<p>Continued From page 67</p> <p>indicator for the monitoring of the effectiveness of the QA process will be utilized monthly X 2 months and then quarterly under the supervision of the Administrator. The Corporate Consultant will review the completed CQI indicator to determine if an action plan is indicated for any identified issues. A Diabetes Management skills check list is being completed on two licensed nursing staff daily for two weeks, and then weekly for four weeks, and then monthly for three months, and then quarterly thereafter by the DON/Pharmacy Consultant/Administrative Nursing/Nursing Consultant during observations of finger stick glucose testing and insulin preparation/administration to determine compliance with these procedures and accurate insulin administration.</p> <p>Criteria #5: March 17, 2011.</p> <p>During the extended survey, on 03/16/11 through 03/18/11, verification of the removal of Immediate Jeopardy was completed as follows:</p> <p>Interviews with Registered Nurse (RN) #1, RN #2, RN #3, LPN #8, LPN #9, LPN #10, LPN #11, LPN #12 and LPN #13, on 03/17/11 at 2:25 PM, on 03/18/11 at 9:00 AM, on 03/17/11 at 11:35 AM, on 03/17/11 at 2:17 PM, on 03/18/11 at 9:30 AM, on 03/17/11 at 1:55 PM, on 03/17/11 at 10 :35 AM, on 03/17/11 at 3:00 PM and on 03/17/11 at 1:50 PM respectively, revealed the licensed staff were educated regarding notification of the physician for finger stick glucose results in accordance with physician ordered parameters, physician notification of assessment findings related to resident change in status, administration of insulin in accordance with physician orders to prevent a significant medication error; the need to notify the</p>	F 520			

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NAME OF PROVIDER OR SUPPLIER GREEN ACRES HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 402 W. FARTHING STREET MAYFIELD, KY 42066		
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F 520	<p>Continued From page 68</p> <p>physician if the residents status denotes that insulin order changes may be indicated; physician ordered parameters for the reporting of glucose finger stick results; the calculation of sliding scale insulin dosage in accordance with physician orders; and the protocol for two nurses to verify and initial routine and sliding scale insulin doses administered to residents. The interviews revealed the staff understood the content of the inservice and individual responsibility.</p> <p>Observations of RN #1, LPN #11 and LPN #13, on 03/17/11 between 11:00 AM and 11:45 AM, revealed staff obtained accuchecks on five residents and administered insulin to four residents. Insulin doses were verified by two licensed staff as directed by the AoC. Both routine insulin and sliding scale insulin was administered in accordance with the written physician order.</p> <p>A record review, on 03/17/11 at 10:30 AM, revealed the facility had Initiated Diabetic Management check lists for all licensed nursing staff on 03/11/11 and had completed 16 competency checks at the time of review with the process continuing until all licensed nursing staff had been checked off.</p> <p>A record review, on 03/17/11 at 10:35 AM, revealed all licensed nursing staff had completed a written test on medication administration and review of the test revealed questions pertained to Diabetes, insulin and insulin administration including questions requiring the staff to calculate sliding scale insulin doses.</p> <p>A review of all residents records with the diagnosis of Diabetes who also received either</p>	F 520			

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NAME OF PROVIDER OR SUPPLIER GREEN ACRES HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 402 W. FARTHING STREET MAYFIELD, KY 42066		
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F 520	<p>Continued From page 69</p> <p>sliding scale insulin or routine insulin, on 03/17/11 at 1150.AM, revealed all residents had the new Diabetic Record in place with physician established parameters for physician notification regarding both high and low blood sugar levels. Record review also revealed four residents with the diagnosis of Diabetes, who only had accuchecks ordered but did not have orders for insulin, had the new Diabetic Record in place with established parameters for physician notification regarding abnormal blood sugar levels.</p> <p>A review of the facility's audit of other residents with the potential to be affected by the deficient practice revealed the facility identified other residents affected by the practice and notified the physician of each resident affected by the deficient practice.</p> <p>A review of sign-in sheets for all in-services the facility provided in response to the Immediate Jeopardy revealed all licensed staff had attended the training sessions except one staff member who was hospitalized.</p> <p>An interview with the DON, on 03/17/11 at 2:00 PM, revealed the DON would monitor the Continuous Quality Improvement (CQI) by auditing all diabetic records weekly for one month and then five chosen randomly on a monthly basis thereafter to determine compliance with the facility policy/procedure and physician orders. The DON stated the audit would include whether the resident had Diabetes identified through the care plan process, monitoring of the diabetic record to ensure accuracy and completion, parameters for hypoglycemia and hyperglycemia were listed on both the Diabetic Record and the physician orders and documentation of evening</p>	F 520			

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NAME OF PROVIDER OR SUPPLIER GREEN ACRES HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 402 W. FARTHING STREET MAYFIELD, KY 42066		
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F 520	<p>Continued From page 70</p> <p>snacks provided to Diabetic residents. She stated all hypo and hyperglycemic events would be reviewed to ensure all protocols were followed. The DON stated if audits do not demonstrate at least 95 percent compliance, an action plan would be developed immediately to address any identified problems.</p> <p>An interview with the Administrator, on 03/18/11 at 11:15 AM, revealed he would be completing a check list after reviewing audits completed by the DON to ensure policy and procedure was followed correctly and if any problem were to be identified regarding audits not being completed as directed by the AoC, he would initiate disciplinary action.</p> <p>Based on the above observations, interviews and review of records, it was determined the Immediate Jeopardy was removed, effective 03/17/11, as alleged in the AoC with the scope and severity lowered to an "E", based on the need to continue to evaluate the implementation of changes and quality assurance activities.</p>	F 520			

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NAME OF PROVIDER OR SUPPLIER GREEN ACRES HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 402 W. FARTHING STREET MAYFIELD, KY 42066		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and conducted on 02/22/11 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.	K 000			

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

TITLE

(X6) DATE

Just Hall

Administrator

April 7, 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.