11/8/8

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

RECEIVED
JUN 2011
OFFICE OF INSPECTOR GENERAL

PRINTED: 06/07/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185341		R 05/20/2011

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 000}	INITIAL COMMENTS An on-site revisit was conducted on 05/18/11-05/20/11, to determine the facility's compliance with Federal Regulatory Requirements. Continued non-compliance remained at 483.20 (F-281) at a S/S of a "D", 483.75 (F-490) at a S/S of a "D" and 483.75 (F-520) at a S/S of a "D". Deficient practice was identified at 483.10 (F-157) at a S/S of a "D".	{F 000}	**Disclaimer: Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.**	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	**483.10(b)(11) NOTIFY OF CHANGES** The facility shall immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is (A) An accident involving the resident which results in injury and has the potential for requiring physician interventions; (B) A significant change in the resident's physical, mental, or psychosocial status; (C) A need to alter treatment significantly; or (D) A decision to transfer or discharge the resident from the facility as specified in §483.12(a). **Criteria 1** – On 5/19/11, resident #4's MD was notified of the finger-stick blood sugar (FSBS) of 54 that was obtained on 5/4/11; and that the resident was given 4 oz. of juice then a follow-up FSBS was obtained 15 minutes later as per facility hypoglycemia protocol. The MD did not alter treatment following the notification. **Criteria 2** – All diabetic residents had the potential for being affected by this alleged deficient practice, there were no other occurrences of an attending MD not being notified of out of parameter FSBS, as per MD orders, prior to survey exit on 5/20/11. **Criteria 3** – Licensed Nurses (LN) received in-service education on 6/6/11 by the Certified Diabetic Educator from Jackson Purchase Medical Center on care of the Diabetic Resident. The in-service included, but was not limited to: signs/symptoms of hypo/ hyperglycemia, facility policy and protocol for treatment of hypo/hyperglycemia, completion of the diabetic record, facility MD/Legal Representative policy, importance of HS snacks and diets associated with diabetes, following MD orders regarding notification of FSBS out of set parameters, and	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Teri D Pruner — TITLE: Administrator — (X6) DATE: 6/8/2011

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.

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy and procedures it was determined the facility failed to immediately notify the physician when there was a need to alter the treatment related to a clinical symptom for one resident (#4) in the selected sample of nine residents. Resident #4 had written orders to notify the physician of any blood sugar levels less than 70 milligrams/deciliter (mg/dl) or greater than 300 mg/dl. The facility failed to notify the physician of Resident #4's blood sugar level of 54 mg/dl on 05/04/11. The findings include: A review of the facility's policy, Physician/Legal Representative Notification, dated revised August 2006, revealed the facility would immediately inform the resident, consult with the resident's attending physician, and if known, notify the resident's legal representative or an interested family member when there was a need to alter treatment significantly. The policy/procedure revealed the facility would notify the physician when a need to alter treatment was indicated. The charge nurse would make two attempts to notify the attending physician within a ten minute period. If unsuccessful, the charge nurse would notify the physician on call or the Medical Director.	F 157	protocol for second nurse verification of insulin dose. Those LN's unable to attend on 6/6/11, received the in-service education on their next scheduled work day by the DON and/or ADON. The DON, ADON, MDS Coordinator and Administrator received in-service education on 6/6/11 by the Certified Diabetic Education from Jackson Purchase Medical Center on the above mentioned diabetic care issues to better prepare them to provide in-service education to licensed nurses who were unable to attend the 6/6/11 in-service and other LN's as needed. Licensed Nurses (LN) received in-service education on 5/20/11 and 5/24/11 by the DON on Physician Notification of FSBS's out of high/low parameters according to physician orders. The facility Interim Administrator, DON and corporate QA Nurse received in-service education on 5/24/11 by the corporate Director of Clinical Services on Federal Regulation F 157. The current Administrator (began 5/31/11) received this same in-service education on 6/6/11 by the corporate Director of Clinical Services. **Criteria 4** - The DON and/or ADON will review the Diabetic Records of all diabetic residents daily X 30 days, then twice a week X 2 weeks, then weekly X 4, then quarterly thereafter. The audit form includes the names and diabetic orders for each resident that requires FSBS monitoring. Each audit will consist of a 24 hour period review (0600-0600); after the initial 30 days of daily audit reviews are completed, the audits will be conducted on different days of the week to ensure a variety of LN's are being monitored. If at anytime the audits reveal a potential problem, then the frequency of audits may be increased temporarily as indicated by audit findings as determined by the Administrator. The corporate QA Nurse shall review all diabetic record audits to ensure that proper corrective actions were completed as indicated. The facility administrator shall sign off on all CQI action plans completed due to potential problems identified through the diabetic record audits.	

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F 157	Continued From page 2 A record review revealed Resident #4 was admitted to the facility on 12/22/10 with diagnoses to include Diabetes. A review of Resident #4's physician orders, dated 03/07/11, revealed an order to notify the physician for blood sugar levels less than 70 mg/dl or greater than 300 mg/dl. A review of the resident's diabetic record, dated May 2011, revealed, on 05/04/11 at 6:00 AM, the resident's blood sugar level was 54 mg/dl. Record review revealed no documented evidence the resident's physician was notified of the resident's blood sugar level. Interviews, on 05/19/11 at 3:00 PM and on 05/20/11 at 11:55 AM with Registered Nurse (RN) #1 who obtained Resident #4's blood sugar level on 05/04/11, revealed she did not contact the physician about the blood sugar level. She stated the Director of Nursing (DON) brought the error to her attention two days later, on 05/06/11. However, she received no instructions to notify the physician of the blood sugar level at that time, and she failed to notify the physician of the blood sugar level, on 05/06/11. Interviews with the DON, on 05/19/11 at 2:05 PM and on 05/20/11 at 1:30 PM, revealed she identified the failure to notify the physician of the blood sugar level as a result of an informal audit she conducted on Resident #4's diabetic record on 05/06/11. Per interview, she failed to instruct the staff member to notify the physician when the error was discovered. The DON revealed she expected staff to notify the physician at the time the blood sugar level was obtained if the level was outside of the established parameters for the resident.	F 157	A Diabetes Management skills check list is being completed on 2 licensed nursing staff weekly for 1 month, then monthly for 3 months and then quarterly thereafter by the DON, Pharmacy Consultant, Administrative Nurse, or Nursing Consultant during observations of finger stick glucose testing and insulin preparation administration to determine compliance with these procedures and physician orders. The CQI indicator tool for the monitoring of Diabetes Management (tool N-25) shall be utilized monthly X 3 and then quarterly thereafter, under the supervision of the DON. The tool shall be completed on 5 randomly chosen diabetic residents; there will be an identifier list with the tool to ensure that the sample of residents is rotated. **Criteria 5** – Target Date	6/9/11

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F 157	Continued From page 3	F 157		
	An interview with Resident #4's attending physician, on 05/20/11 at 10:50 AM, revealed the orders written on 03/07/11 established parameters for notification regarding blood sugar levels so the facility would have set guidelines to contact him when levels were outside of the established parameters.			
{F 281} SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure services provided or arranged by the facility met professional standards of quality related to failure to carry out the written physician's order for one resident (#4), in the selected sample of nine residents. The facility failed to follow the physician's order to notify the physician of a blood sugar level less than 70 milligrams/deciliter (mg/dl). Resident #4's blood sugar level was 54 mg/dl on 05/04/11. The findings include: A record review revealed Resident #4 was admitted to the facility on 12/22/10 with diagnoses to include Diabetes. A review of Resident #4's physician orders, dated 03/07/11, revealed an order to notify the physician for blood sugar levels less than 70 mg/dl or greater than 300 mg/dl. A review of the resident's diabetic record, dated	{F 281}	**483.20(k)(3)(i) Services Provided Meet Professional Standards** The services provided or arranged by the facility shall meet professional standards of quality: **Criteria 1** – On 5/19/11, resident #4's MD was notified of the finger-stick blood sugar (FSBS) of 54 that was obtained on 5/4/11; and that the resident was given 4 oz. of juice then a follow-up FSBS was obtained 15 minutes later as per facility hypoglycemia protocol. The MD did not alter treatment following the notification. **Criteria 2** – All diabetic residents had the potential for being affected by this alleged deficient practice, there were no other occurrences of an attending MD not being notified of out of parameter FSBS, as per MD orders, prior to survey exit on 5/20/11. **Criteria 3** – Licensed Nurses (LN) received in-service education on 6/6/11 by the Certified Diabetic Educator from Jackson Purchase Medical Center on care of the Diabetic Resident. The in-service included, but was not limited to: signs/symptoms of hypo/ hyperglycemia, facility policy and protocol for treatment of hypo/hyperglycemia, completion of the diabetic record, facility MD/Legal Representative policy, importance of HS snacks and diets associated with diabetes, following MD orders regarding notification of FSBS out of set parameters, and protocol for second nurse verification of insulin dose. Those LN's unable to attend on 6/6/11, received the in-service education on their next scheduled work day by the DON and/or ADON. The DON, ADON, MDS Coordinator and Administrator received in-service education on 6/6/11	

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{F 281}	Continued From page 4 May 2011, revealed on 05/04/11 at 6:00 AM the resident's blood sugar level was 54 mg/dl. Interviews with Registered Nurse (RN) #1, on 05/19/11 at 3:00 PM and on 05/20/11 at 11:55 AM, revealed RN #1 had obtained Resident #4's blood sugar level at 6:00 AM on 05/04/11 and the result was 54 mg/dl. RN #1 revealed she did not contact the physician about the blood sugar level. She stated the Director of Nursing (DON) brought the error to her attention two days later, on 05/06/11. RN #1 revealed she received no instructions to notify the physician of the blood sugar level on 05/06/11 when the error was brought to her attention.. Interviews with the DON, on 05/19/11 at 2:05 PM and on 05/20/11 at 1:30 PM, revealed she identified the failure to notify the physician of the blood sugar level as a result of an informal audit she conducted on Resident #4's diabetic record on 05/06/11. She revealed RN #1 received disciplinary action as a result of the failure to notify the physician, but failed to instruct the staff member to notify the physician when the error was discovered. The DON revealed she expected staff to carry out the physician's order and notify the physician if the level was outside of the established parameters for the resident. An interview with Resident #4's attending physician, on 05/20/11 at 10:50 AM, revealed the orders written on 03/07/11 established parameters for notification regarding blood sugar levels so the facility would have set guidelines to contact him when levels were outside of the established parameters.	{F 281}	by the Certified Diabetic Education from Jackson Purchase Medical Center on the above mentioned diabetic care issues to better prepare them to provide in-service education to licensed nurses who were unable to attend the 6/6/11 in-service and other LN's as needed. Licensed Nurses (LN) received in-service education on 5/20/11 and 5/24/11 by the DON on Physician Notification of FSBS's out of high/low parameters according to physician orders. **Criteria 4** - The DON and/or ADON will review the Diabetic Records of all diabetic residents daily X 30 days, then twice a week X 2 weeks, then weekly X 4, then quarterly thereafter. The audit form includes the names and diabetic orders for each resident that requires FSBS monitoring. Each audit will consist of a 24 hour period review (0600-0600); after the initial 30 days of daily audit reviews are completed, the audits will be conducted on different days of the week to ensure a variety of LN's are being monitored. If at anytime the audits reveal a potential problem, then the frequency of audits may be increased temporarily as indicated by audit findings as determined by the Administrator. The corporate QA Nurse shall review all diabetic record audits to ensure that proper corrective actions were completed as indicated. The facility administrator shall sign off on all CQI action plans completed due to potential problems identified through the diabetic record audits. A Diabetes Management skills check list is being completed on 2 licensed nursing staff weekly for 1 month, then monthly for 3 months and then quarterly thereafter by the DON, Pharmacy Consultant, Administrative Nurse, or Nursing Consultant during observations of finger stick glucose testing and insulin preparation administration to determine compliance with these procedures and physician orders. The CQI indicator tool for the monitoring of Diabetes Management (tool N-25) shall be utilized monthly X 3 and then quarterly thereafter, under the supervision of the DON. The tool shall be completed on 5	
{F 490}	483.75 EFFECTIVE	{F 490}		

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{F 490} SS=D	Continued From page 5 ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's Plan of Correction for the 03/18/11 survey it was determined the facility was not administered effectively to ensure the facility's resources were used effectively and efficiently to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being. The facility failed to ensure the Plan of Correction was implemented to ensure continued compliance related to following physician orders and physician notification of an abnormal blood sugar level in accordance with the written physician's orders. The findings include: Review of the facility's Plan of Correction (POC) for the survey conducted on 03/18/11 revealed the Director of Nursing (DON) and the licensed nursing staff received in-service education regarding regulatory requirements and policy and procedures related to "notification of the MD for finger stick glucose results in accordance with MD ordered parameters" and following "physician ordered parameters for the reporting of glucose finger stick results". Further review of the POC revealed the "CQI indicator for the monitoring of	{F 490}	randomly chosen diabetic residents; there will be an identifier list with the tool to ensure that the sample of residents is rotated. **Criteria 5** – Target Date **483.75 Effective Administration/ Resident Well-Being** The facility shall be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident: **Criteria 1** – On 5/19/11, resident #4's MD was notified of the finger-stick blood sugar (FSBS) of 54 that was obtained on 5/4/11; and that the resident was given 4 oz. of juice then a follow-up FSBS was obtained 15 minutes later as per facility hypoglycemia protocol. The MD did not alter treatment following the notification. **Criteria 2** – All diabetic residents had the potential for being affected by this alleged deficient practice, there were no other occurrences of an attending MD not being notified of out of parameter FSBS, as per MD orders, prior to survey exit on 5/20/11. **Criteria 3** – The Interim Administrator, DON and corporate QA Nurse received in-service education on 05/24/11 on the QA process by the corporate Director of Clinical Services. The in-service included: if failure to notify the physician and/or resident legal /representative is identified through the QA process, then the facility is to take action to notify the physician and/or legal representative at the time the oversight is identified; and the notification is to be documented in the resident clinical record and with the QA information which led to the identification of the event. The current Administrator (began 5/31/11) received the above mentioned in-service education on 6/6/11 by the corporate Director of Clinical Services. 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	6/9/11

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{F 490}	Continued From page 6 compliance with the facility policy/procedure and MD orders for Diabetes Management will be utilized monthly x 2 months"....."The Administrator will review the completed CQI Indicator to determine compliance and to determine if an action plan is indicated for any identified issues". Interview and record review revealed the facility failed to ensure licensed staff provided services that met professional standards of quality for Resident #4. On 05/04/11, licensed staff failed to notify the attending physician of an abnormal blood sugar reading of 54 milligrams per deciliter (mg/dl) as directed by the written physicians order. (Refer to F157 and F281) An interview with the former facility administrator, (resigned effective 05/13/11), on 05/20/11 2:00 PM, revealed he was aware of the facility's continued non-compliance for following written physician's orders. He stated the DON had brought the incident to his attention when she had identified the problem on 05/06/11. He revealed the facility addressed the problem through corrective action with the Registered Nurse (RN) involved in the incident, but made no revisions to the process the facility utilized to identify and address issues as directed by the POC. An interview with the facility owner and acting administrator, on 05/20/11 at 3:00 PM, revealed he was aware of facility's continued non-compliance for following written physician's orders and physician notification. He revealed the incident was identified through an informal audit conducted by the DON and was addressed through corrective action with the RN involved in	{F 490}	with State and Federal regulations regarding resident rights, resident assessment and administration. **Criteria 4** – The DON and/or ADON will review the Diabetic Records of all diabetic residents daily X 30 days, then twice a week X 2 weeks, then weekly X 4, then quarterly thereafter. The audit form includes the names and diabetic orders for each resident that requires FSBS monitoring. Each audit will consist of a 24 hour period review (0600-0600); after the initial 30 days of daily audit reviews are completed, the audits will be conducted on different days of the week to ensure a variety of LN's are being monitored. If at anytime the audits reveal a potential problem, then the frequency of audits may be increased temporarily as indicated by audit findings as determined by the Administrator. The corporate QA Nurse shall review all diabetic record audits to ensure that proper corrective actions were completed as indicated. The facility administrator shall sign off on all CQI action plans completed due to potential problems identified through the diabetic record audits. A Diabetes Management skills check list is being completed on 2 licensed nursing staff weekly for 1 month, then monthly for 3 months and then quarterly thereafter by the DON, Pharmacy Consultant, Administrative Nurse, or Nursing Consultant during observations of finger stick glucose testing and insulin preparation administration to determine compliance with these procedures and physician orders. The CQI indicator tool for the monitoring of Diabetes Management (tool N-25) shall be utilized monthly X 3 and then quarterly thereafter, under the supervision of the DON. The tool shall be completed on 5 randomly chosen diabetic residents; there will be an identifier list with the tool to ensure that the sample of residents is rotated. **Criteria 5** – Target Date	6/9/11

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{F 490}	Continued From page 7 the incident. He stated this approach was effective and the facility had not revised their process for identifying and addressing issues as directed by the POC.	{F 490}		
{F 520} SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS 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. 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. 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. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's Plan of Correction for the 04/14/11 revisit it was determined the facility failed to	{F 520}	**483.75(o)(1) QAA Committee-Members / Meet Quarterly/Plans** 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: **Criteria 1** – On 5/19/11, resident #4's MD was notified of the finger-stick blood sugar (FSBS) of 54 that was obtained on 5/4/11; and that the resident was given 4 oz. of juice then a follow-up FSBS was obtained 15 minutes later as per facility hypoglycemia protocol. The MD did not alter treatment following the notification. **Criteria 2** – All diabetic residents had the potential for being affected by this alleged deficient practice, there were no other occurrences of an attending MD not being notified of out of parameter FSBS, as per MD orders, prior to survey exit on 5/20/11. **Criteria 3** – The Interim Administrator, DON and corporate QA Nurse received in-service education on 05/24/11 on the QA process by the corporate Director of Clinical Services. The in-service included: if failure to notify the physician and/or resident legal representative is identified through the QA process,	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185341		R 05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN ACRES HEALTH CARE	402 W. FARTHING STREET MAYFIELD, KY 42066

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{F 520}	Continued From page 8 ensure the Quality Assurance Program (QA) was effective to identify and address continued non-compliance regarding failure to ensure physician notification for a need to alter treatment and to follow written physician's orders for one resident (#4) in the selected sample of nine. The Director of Nursing (DON) identified, through a QA review of the resident's record, the facility failed to notify Resident #4's physician of an abnormal blood sugar level as directed by the written physician's order, but failed to notify the physician or instruct the licensed staff, who had obtained the blood sugar level, to notify the physician of the results. The findings include: Review of the facility's Plan of Correction (POC) for the 03/18/11 survey for F157 revealed "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 compliance with the facility policies/procedures and MD orders". Review of the facility's Plan of Correction (POC) for the 04/14/11 revisit for F281 revealed the "DON and/or nurse consultant will review the Diabetic Records of 5 randomly chosen residents on a monthly basis to determine compliance with the facility polices/procedures and MD orders." Interview and record review revealed the facility failed to ensure licensed staff provided services that met professional standards of quality for Resident #4. On 05/04/11, licensed staff failed to notify the attending physician of an abnormal blood sugar reading of 54 milligrams per deciliter (mg/dl) as directed by the written physicians	{F 520}	then the facility is to take action to notify the physician and/or legal representative at the time the oversight is identified; and the notification is to be documented in the resident clinical record and with the QA information which led to the identification of the event. The current Administrator (began 5/31/11) received the above mentioned in-service education on 6/6/11 by the corporate Director of Clinical Services. 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, resident assessment and administration. **Criteria 4** – The DON and/or ADON will review the Diabetic Records of all diabetic residents daily X 30 days, then twice a week X 2 weeks, then weekly X 4 then quarterly thereafter. The audit form includes the names and diabetic orders for each resident that requires FSBS monitoring. Each audit will consist of a 24 hour period review (0600-0600); after the initial 30 days of daily audit reviews are completed, the audits will be conducted on different days of the week to ensure a variety of LN's are being monitored. If at anytime the audits reveal a potential problem, then the frequency of audits may be increased temporarily as indicated by audit findings as determined by the Administrator. The corporate QA Nurse shall review all diabetic record audits to ensure that proper corrective actions were completed as indicated. The facility administrator shall sign off on all CQI action plans completed due to potential problems identified through the diabetic record audits. 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 indictor to determine if an action plan is indicated for any identified issues. A Diabetes Management skills check list is being	

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{F 520}	Continued From page 9 order. (Refer to F157 and F281) Interviews with the Director of Nursing (DON), on 05/19/11 at 2:05 PM and on 05/20/11 at 1:30 PM, revealed she completed the required audit of five randomly chosen resident Diabetic Records and found no issues. Later, as a result of an informal QA audit on 05/06/11, she reviewed Resident #4's record and identified the failure to notify the physician of the blood sugar level. She revealed the facility administrator was aware of the issue and no changes were made to the facility's process for monitoring or addressing issues identified through the QA process. An interview with the former facility administrator, (resigned effective 05/13/11), on 05/20/11 2:00 PM, and the facility owner and acting administrator, on 05/20/11 at 3:00 PM, revealed both were aware of facility's continued non-compliance for following written physician's orders and physician notification. However, neither had made revisions to the process the facility utilized to identify, address, or monitor issues as directed by the POC.	{F 520}	completed on 2 licensed nursing staff weekly for 1 month, then monthly for 3 months and then quarterly thereafter by the DON, Pharmacy Consultant, Administrative Nurse, or /Nursing Consultant during observations of finger stick glucose testing and insulin preparation administration to determine compliance with these procedures and physician orders. **Criteria 5** – Target Date	6/9/11

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

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{F 000}	INITIAL COMMENTS An on-site revisit was conducted on 04/13/11-04/14/11, to determine the facility's compliance with Federal Regulatory Requirements. Continued non-compliance remained at 483.20 (F-281) at a S/S of a "D" and 483.75 (F-520) at a S/S of a "D". Deficient practice was identified at 483.75 (F-490) at a S/S of a "D".	{F 000}	**Disclaimer: Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.**	
{F 281} SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of the facility's policy and procedures it was determined the facility failed to ensure licensed staff provided services that met professional standards of quality, for one of ten sampled residents (Resident (#8). On 03/24/11, licensed staff administered 16 units of Novolog insulin to Resident #8. Record review revealed no documented evidence there was an order for the 16 units of insulin. The findings include: A review of the facility's "Medication Administration-General Guidelines" policy and procedure, not dated, revealed medications were to be administered in accordance with written orders of the attending physician. A record review revealed Resident #8 was admitted to the facility on 12/26/08 with a	{F 281}	**483.20(k)(3)(i) Services Provided Meet Professional Standards** The services provided or arranged by the facility shall meet professional standards of quality: **Criteria 1** - The telephone order received from Resident #8's attending physician by the charge nurse involved on 3/24/11 was documented on 4/14/11 by the same charge nurse involved and filed in resident #8's medical record. Disciplinary action was taken with the charge nurse involved. **Criteria 2** - An audit of all current residents' diabetic records for the past 30 days was completed on 4/15/11 by the nurse consultant to ensure that Sliding Scale Insulin (SSI) was being given in accordance with physician orders. Disciplinary action with nursing staff was completed as indicated. **Criteria 3** - Licensed Nurses (LN) have received in-service education on 4/18-22/11 by the nurse consultant, DON and/or ADON on the following diabetic issues that were identified by the 4/15/11 audit: (1) PRN finger stick blood sugar (FSBS) may be done based on nurses' judgment, but PRN sliding scale insulin (SSI) can not be given without a physician's order. (2) FSBS and insulin administration is to be documented at the time completed. (3) Insulin is to be held	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: May 5, 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.

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{F 281}	Continued From page 1 diagnosis of Diabetes Mellitus. A review of the Physician's order, dated 02/04/11 and 03/07/11, revealed Novolog 100 units/milliliter vial was to be administered per the following sliding scale insulin parameters: blood sugar minus 100 divided by 30 equals number of insulin units if blood sugar (B/S) greater than 200. Furhter review of the Physician's orders revealed an order, dated 03/07/11, which specified to call the Physician if the resident's B/S was below 50 or above 400. A review of a Diabetic Record revealed Resident #8's blood sugar was 418 on 03/24/11 at 11:30 AM and 16 units of Novolog insulin was administered. A review of the Physician's orders revealed there was no order for the 16 units of insulin. An interview with Licensed Practical Nurse (LPN) #1, on 04/14/11 at 9:30 AM, revealed she called the Physician and made him aware Resident #8's blood sugar was 418. She stated the Physician gave an order to give 16 units of Novolog insulin. She stated she must have forgotten to write the Physician's order and chart in the Nurses Notes. An interview with the Director of Nursing, on 04/14/11 at 10:00 AM, revealed the Nurse should have called the Physician and wrote the Physician's order. She stated the Nurse should have documented in the resident's record that the blood sugar was greater than 400, the Physician was called, and a new order was received. Interview with Resident #8's Physician, on 04/14/11 at approximately 2:00 PM, revealed he could not recall if the Nurse called him related to	{F 281}	according to MD orders; notify MD as indicated. (4) SSI chart – facility has developed a SSI chart for calculation of SSI dose for those residents with formularies (i.e., FSBS – 100 / 30 = SSI dose). (5) Verification of insulin dose by second nurse is to be done visually and documented on the diabetic record. **Criteria 4** - The DON and/or nurse consultant will review the Diabetic Records of 5 randomly chosen residents on a monthly basis 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 indictor to determine if an action plan is indicated for any identified issues. **Criteria 5** – Target Date	04/23/11

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{F 281}	Continued From page 2 Resident #8's blood sugar of 418 or if he had given an order to administer 16 units of Novolog insulin. He stated 16 units of Novolog sounded like the amount he would of ordered if Resident 8's B/S was 418. Review of the twenty-four hour report, dated 03/24/11, revealed a note the Physician was contacted on 03/24/11 with new orders received; however, the insulin dosage was not indicated and there was no evidence in Resident #8's clinical record the order for 16 units of Novolog had been received.	{F 281}		
F 490 SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedures, Compliance Checklist, and Plan of Correction (PoC) it was determined the facility was not administered effectively to ensure the facility's resources were used effectively and efficiently to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being. The facility failed to ensure policy and procedures was followed to assure medications were administered in accordance with written Physician's orders. The facility failed to ensure the Plan of Correction was implemented to correct deficient practice related to administering	F 490	**483.75 Effective Administration/ Resident Well-Being** The facility shall be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident: **Criteria 1** – Resident #8's diabetic record is being completed thoroughly and accurately as of 04/18/11. Previous documentation errors noted on resident #8's diabetic record have been addressed on a CQI Action Plan. The telephone order received by the charge nurse involved on 3/24/11 was documented on 4/14/11 by the same charge nurse involved and filed in resident #8's medical record. **Criteria 2** – An audit of all current residents' diabetic records for the past 30 days was completed on 4/15/11 by the nurse consultant. Any identified documentation errors noted have been addressed on a CQI Action Plan. **Criteria 3** – Licensed Nurses (LN) have received in-service education on 4/18-22/11 by the nurse consultant, DON and/or ADON on the following diabetic issues: (1) PRN finger stick blood sugar (FSBS) may be done based on nurses' judgment, but PRN sliding scale insulin (SSI) can not be given without an order.	

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F 490	Continued From page 3 medication in accordance to the Physician's orders and to ensure the facility's Quality Assurance Program was effective to identify continued non-compliance. Review of the facility's PoC revealed the Director of Nursing (DON) and/or the Nurse Consultant would review all facility Diabetic Records to determine compliance with the facility's policies and procedures and physician's orders. The Director of Nursing failed to ensure the Quality Assurance Program and PoC were implemented in a manner to identify Resident #8 received 16 units of Novolog insulin, on 03/24/11, without a Physician's order. The findings include: Based on interview and record review it was determined the facility failed to ensure licensed staff provided services that met professional standards of quality for Resident #8. On 03/24/11, licensed staff administered 16 units of Novolog insulin to Resident #8. Record review revealed no documented evidence there was an order for the 16 units of insulin. (Refer to F281) Based on interviews and record reviews it was determined the facility failed to implement their PoC identify quality concerns related to following Physician's orders for Resident #8. A review of the facility's PoC revealed the DON and/or Nurse consultant would review all facility Diabetic Records weekly times one month (03/12/11-04/01/11) to determine compliance with the facility's policies and procedures and Physician's orders. A review of Resident #1's Diabetic Record for 03/24/11 revealed Resident #1's blood sugar was 418 and 16 units of insulin was given. A review of the Physician's orders	F 490	(2) FSBS and insulin administration is to be documented at the time completed. (3) Insulin is to be held according to MD orders; notify MD as indicated. (4) SSI chart – facility has developed a SSI chart for calculation of SSI dose for those residents with formularies (i.e., FSBS – 100 / 30 = SSI dose). (5) Verification of insulin dose by second nurse is to be done visually and documented on the diabetic record. The Administrator, DON and ADON have received in-service education on the facility's CQI program on 4/15/11 by the nurse consultant. This in-service included, but was not limited to: resident identification on audit forms when indicated, documentation of problems/ concerns identified, using a tracking system for follow-through and monitoring of action plans for effectiveness. 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. **Criteria 4** – The DON and/or nurse consultant will review the Diabetic Records of 5 randomly chosen residents on a monthly basis 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 indictor to determine if an action plan is indicated for any identified issues.	

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F 490	Continued From page 4 revealed there was no Physician's order to administer 16 units of Novolog insulin. A review of the facility's Compliance Checklist revealed there was no evidence the facility had identified there was no Physician's order for the 16 units of insulin. (Refer to F520) An interview with the DON, on 04/14/11 at 10:00 AM, revealed the Compliance Checklist indicated that all Diabetic Records had been reviewed and the check marks on the form indicated the Diabetic Sheets were reviewed and all concerns identified were corrected immediately. Per interview, the DON could not explain why Resident #8's insulin administration, on 03/24/11 without a Physician's order, had not been identified on the Compliance Checklist. Further interview on 04/14/11 at 11:00 AM with the DON, revealed she had identified these concerns for Resident #8, but had not documented this on the checklist. She further stated she had told the Nurse to correct the concerns by making a late entry in the clinical record; however, she did not follow-up to ensure the corrections were made.	F 490	**Criteria 5** – Target Date	04/23/11
{F 520} SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS 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. 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	{F 520}	**483.75(o)(1) QAA Committee-Members / Meet Quarterly/Plans** 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	

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{F 520}	Continued From page 5 develops and implements appropriate plans of action to correct identified quality deficiencies. 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. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedures, facility's Compliance Checklist, and Plan of Correction (PoC) it was determined the facility failed to implement their PoC to identify quality concerns related to following physician's orders for one resident of ten sampled residents (Resident #8). Review of the facility's PoC revealed the DON and/or Nurse Consultant would review all facility Diabetic Records weekly times one month (03/12/11-04/01/11) to determine compliance with the facility's policies and procedures and physician's orders. Review of Resident #8's Diabetic Record for 03/24/11 revealed the resident's blood sugar was 418 and 16 units of Novolog insulin was given. However, review of the Physician's orders revealed there was no Physician order to administer Novolog 16 units. (Refer to F281) A review of the facility's monitoring information indicated Resident #8's Diabetic Record had been reviewed on 03/25/11 and 04/01/11 and there was no evidence any concerns were identified related to Resident #8.	{F 520}	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: **Criteria 1** – Resident #8's diabetic record is being completed thoroughly and accurately as of 04/18/11. Previous documentation errors noted on resident #8's diabetic record have been addressed on a CQI Action Plan. The telephone order received by the charge nurse involved on 3/24/11 was documented on 4/14/11 by the same charge nurse involved and filed in resident #8's medical record. **Criteria 2** – An audit of all current residents' diabetic records for the past 30 days was completed on 4/15/11 by the nurse consultant. Any identified documentation errors noted have been addressed on a CQI Action Plan. **Criteria 3** – Licensed Nurses (LN) have received in-service education on 4/18-22/11 by the nurse consultant, DON and/or ADON on the following diabetic issues: (1) PRN finger stick blood sugar (FSBS) may be done based on nurses' judgment, but PRN sliding scale insulin (SSI) can not be given without an order. (2) FSBS and insulin administration is to be documented at the time completed. (3) Insulin is to be held according to MD orders; notify MD as indicated. (4) SSI chart – facility has developed a SSI chart for calculation of SSI dose for those residents with formularies (i.e., FSBS – 100 / 30 = SSI dose). (5) Verification of insulin dose by second nurse to be done visually and documented on the diabetic record.	

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{F 520}	Continued From page 6 The findings include: A review of the facility's "Quality Assurance Program" policy, last revised 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 were problems or opportunities for improvement. The Executive Quality Assurance Committee was 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 stated the Director of Nursing (DON) was the Quality Assurance Coordinator. A review of the facility's PoC, dated 03/18/11, revealed the DON and/or Nurse Consultant would review all Diabetic Records weekly times one month (03/12/11-04/01/11), then five chosen randomly on a monthly basis thereafter to determine compliance with the facility's policy and procedures and Physician's orders. A record review revealed Resident #8 resided on Hall 100. A review of the Physician's orders, dated 02/04/11 and 03/07/11, revealed Novolog 100 units/milliliter vial, Sliding scale insulin, with the following parameters: blood sugar minus 100 divided by 30 equals number of insulin units if blood sugar (B/S) greater than 200. The Physician was to be notified if the B/S was below 50 or above 400. A review of a Diabetic Record revealed Resident #8's BS was 418 on 03/24/11 at 11:30 AM and 16 units of Novolog insulin was administered.	{F 520}	The Administrator, DON and ADON have received in-service education on the facility's CQI program on 4/15/11 by the nurse consultant. This in-service included, but was not limited to: resident identification on audit forms when indicated, documentation of problems/ concerns identified, using a tracking system for follow-through and monitoring of action plans for effectiveness. 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. **Criteria 4** – The DON and/or nurse consultant will review the Diabetic Records of 5 randomly chosen residents on a monthly basis 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 indictor to determine if an action plan is indicated for any identified issues. **Criteria 5** – Target Date	04/23/11

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	185341		R 04/14/2011

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{F 520}	Continued From page 7 Review of the Nurse's Notes and Physician's orders revealed there was no order for the 16 units of insulin. A review of the facility's Compliance Checklist revealed the Diabetic Records of all residents with Diabetes were checked on 03/12/11, 03/18/11, 03/25/11, and 04/01/11. There was no evidence that any concerns were identified with any of the records. An interview with the DON, Assistant Director of Nursing (ADON), and Corporate Consultant, on 04/14/11 at 10:00 AM, revealed the check marks on the Compliance Checklist indicated that all Diabetic Records on the 100 Hall were reviewed by the DON. The DON stated the check marks indicated the Diabetic Sheets were reviewed and all concerns identified were corrected immediately. The DON revealed she did not recall finding any concerns with any of the Diabetic monitoring on Hall 100. When the DON was made aware of the concerns with Resident #8's Diabetic Flow Sheet, she stated she would have to check her notes and see if she had found anything. Further interview with the DON on 04/14/11 at 11:00 AM, revealed she had identified this discrepancy at the time of the audit, but failed to document the information. Per the DON, she had made the Nurse aware of the identified concerns for Resident #8 at the time of the audit, and the Nurse was supposed to correct them. The DON stated she did not follow up to ensure the corrections were made. However, interview with LPN #1, on 04/14/11 at 9:30 AM, revealed she was not aware she had forgotten to write the Physician's order and document in the Nurse's Note until after surveyor	{F 520}		

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{F 520}	Continued From page 8 intervention.	{F 520}		

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

PRINTED: 04/07/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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F 000	INITIAL COMMENTS An annual survey and abbreviated survey (KY #15870) were conducted 02/22/11 through 03/18/11. Abbreviated survey KY # 15870 was substantiated with deficiencies cited. An extended survey was conducted 03/16-18/11. Immediate Jeopardy was identified in the areas of 483.10, F-157 S/S "K"; 483.20, F-281 S/S "K"; 483.25, F-333 S/S "K"; 483.75, F-520 S/S "K" and substandard Quality of Care in the area of 483.25, F333 S/S "K". Immediate Jeopardy was determined to exist on 09/01/10 and was on going through 01/13/11. The facility was notified of the Immediate Joepardy on 03/08/11. An acceptable AoC was received on 03/16/11, with the facility alleging removal of the IJ on 03/17/11. On site observation during the extended survey determined the Immediate Jeopardy was removed on 03/17/11, as alleged, with the remaining noncompliance lowered to S/S "E" : F-157, F-281, F-333 and F-520.	F 000	**Disclaimer: Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.**	
F 157 SS=K	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge	F 157	**483.10(b)(11) NOTIFY OF CHANGES** The facility shall immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is (A) An accident involving the resident which results in injury and has the potential for requiring physician interventions; (B) A significant change in the resident's physical, mental, or psychosocial status; (C) A need to alter treatment significantly; or (D) A decision to transfer or discharge the resident from the facility as specified in §483.12(a).	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	4-7-11

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.

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F 157	Continued From page 1 the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined the facility failed to immediately consult with the physician when treatment was altered significantly for one of fifteen sampled residents (Resident #14). The facility failed to follow facility policies: Physician/Legal Representative Notification and Medication Administration-General Guidelines. The facility failed to notify the physician when licensed nurses judgement determined a need to alter Resident #14's diabetic treatment. 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. 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	F 157	**Criteria 1:** • Resident #14 no longer resides at the facility. An audit has been completed by the ADON of the Diabetes Management 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. **Criteria 2:** • 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	

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F 157	Continued From page 2 to the physician's order a total of one hundred and ten (110) times. All alterations in the administration of insulin were completed without notification and/or consultation of the physician. As a result Resident #14 was at risk for severe hyperglycemic and hypoglycemic episodes. The facility's failure to notify and/or consult with the physician and failure to administer insulin in accordance with physician orders 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. The findings include: A review of the facility policy, Physician/Legal Representative Notification, revision date August 2006, revealed the facility was to immediately inform the resident, consult with the resident's attending physician: and if known, notify the resident's legal representative or an interested family member when there was a need to alter treatment significantly. The policy/procedure revealed the facility was to notify the physician when a need to alter treatment was indicated. The charge nurse was to make two attempts to notify the attending physician within a ten minute period. If unsuccessful, the charge nurse would notify the physician on call or the Medical Director. A review of the facility's policy entitled, "Medication Administration-General Guidelines," not dated, revealed medications were to be administered as prescribed in accordance with good nursing principles and practices. The procedure portion of the policy revealed medications were to be administered in	F 157	reporting of low and high glucose levels have been obtained for residents receiving insulin injections. The hyperglycemia policy was provided and acknowledged by the facility attending physicians and Medical Director. **Criteria 3:** • 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, (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	

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F 157	Continued From page 3 accordance with written orders of the attending physician. If nursing staff considered a dose excessive, considering the resident's age and/or condition, the nurse was to call the prescriber for clarification. Interviews with the Director of Nursing (DON), 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 expected the licensed staff to notify the physician for direction whenever there was a "HI" glucometer reading as there would be no blood sugar level to base the administration of sliding scale insulin. The facility admitted Resident #14, on 01/10/08, with diagnoses to include Diabetes Mellitis and Chronic Renal Failure. A review of the physician orders, dated 11/20/09, revealed an order to administer Humalog insulin per sliding scale based on the calculation of blood sugar minus 100 divided by 30. Subsequent physician orders, dated 06/01/10, revealed Resident #14 was to receive Lantus insulin 16 units at supper and to continue the same sliding scale insulin. On 09/20/10, the routine Lantus was changed to 12 units in the afternoon. On 10/06/10, routine Lantus was increased to 14 units every day. 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 sugars greater than 250	F 157	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. • 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	

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F 157	Continued From page 4 mg/dl. 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 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 specific dates and diabetic medication dosage administered) Interviews with Licensed Practical Nurse (LPN) #1 through #9, on 03/08/11 at 10:20 AM, on	F 157	with physician orders; and (d) The protocol for 2 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 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. **Criteria 4:** • 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 compliance with the facility policies/procedures and MD orders. • 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	

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F 157	Continued From page 5 03/08/11 at 2:15 PM, on 03/08/11 at 11:15 AM, on 03/07/11 at 4:00 PM, on 03/07/11 at 4:15 PM, on 03/08/11 at 8:45 PM, on 03/08/11 at 9:15 AM, on 03/07/11 at 2:40 PM and on 03/07/11 at 3:00 PM, respectively, revealed the licensed staff routinely altered Resident #14's insulin based on nursing judgement and what each individual nurse felt was best for the resident to maintain an acceptable blood sugar level. The staff revealed they did not contact the physician when altering the resident's dose of insulin. The licensed staff revealed when the glucometer reading was "HI", the sliding scale insulin was administered based on the highest reading the glucometer registered; however, multiple nurses indicated the glucometer registered "HI" above 500 mg/dl, when in fact the glucometer registered up to 550 mg/dl. All licensed staff revealed with a "HI" reading, there was no actual figure to use to calculate the sliding scale insulin. 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 would expect the licensed staff to notify the physician when there was a "HI" glucometer reading and he was unaware the licensed staff were routinely altering the dose of insulin administered to Resident #14. He revealed the staff should have notified himself or the physician on-call anytime there was concern with the administration of any medication and never base administration on nursing judgement without contacting a licensed physician for direction. 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	F 157	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. **Criteria 5:**	03/19/11

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F 157	Continued From page 6 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 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.	F 157		

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F 157	Continued From page 7 Criteria #3: The facility policy/procedure for Diabetes Management, including management of hyperglycemia was reviewed/revised to address the following: A. Obtaining, interpreting, and reporting of glucose finger sticks 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. 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 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: 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. 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.	F 157		

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(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 157	Continued From page 8 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. 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: A. Revisions to the Diabetic Management-Hyperglycemia policy. 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. 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: 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.	F 157		

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	185341		03/18/2011

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F 157	Continued From page 9 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. 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. 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	F 157		

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F 157	Continued From page 10 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. Criteria #5: March 17, 2011. During the extended survey, on 03/16/11 through 03/18/11, verification of the removal of Immediate Jeopardy was completed as follows: 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	F 157		

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F 157	Continued From page 11 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. 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. 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. A record review, on 03/17/11 at 10:35 AM, revealed all licensed nursing staff had completed	F 157		

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F 157	Continued From page 12 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. 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 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. 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. 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. 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	F 157		

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F 157	Continued From page 13 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 157		
F 281 SS=K	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		

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F 281	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined the facility failed to ensure services provided or arranged by the facility met professional standards of quality for one of fifteen sampled residents (Resident #14). The facility failed to ensure insulin was administered in accordance with the written physician order and failed to ensure policy and procedures related to medication administration were followed. 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. As a result, Resident #14 was at risk for severe hyperglycemic and hypoglycemic reactions. The facility's failure to ensure services provided or arranged by the facility met professional standards of quality for insulin administration placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy was identified and the facility was notified, on 03/08/11. The findings include: A review of the facility policy entitled, "Medication Administration-General Guidelines," not dated, revealed medications were to be administered as prescribed in accordance with good nursing	F 281	**483.20(K)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS** The services provided or arranged by the facility shall meet professional standards of quality: **Criteria 1:** • Resident #14 no longer resides at the facility. An audit has been completed by the ADON of the Diabetes Management 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. **Criteria 2:** • 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	

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F 281	Continued From page 15 principles and practices. The procedure portion of the policy revealed medications were to be administered in accordance with written orders of the attending physician. If nursing staff considered a dose excessive, considering the resident's age and/or condition, the nurse was to call the prescriber for clarification. Interviews with Licensed Practical Nurse (LPN) #1, LPN #2, LPN #3, LPN #4, LPN #5, LPN #6, LPN #7, LPN #8 and LPN #9, on 03/08/11 at 10:20 AM, on 03/08/11 at 2:15 PM, on 03/08/11 at 11:15 AM, on 03/07/11 at 4:00 PM, on 03/07/11 at 4:15 PM, on 03/08/11 at 8:45 PM, on 03/08/11 at 9:15 AM, on 03/07/11 at 2:40 PM and on 03/07/11 at 3:00 PM, respectively, revealed the licensed staff routinely altered Resident #14's insulin. Staff interviews revealed they altered the insulin dosage based the resident's food consumption, the resident's history, and staff knowledge of the resident. The facility admitted Resident #14, on 01/10/08, with diagnoses to include Diabetes Mellitis and Chronic Renal Failure. A review of the physician's orders, dated 11/20/09, revealed an order to administer Humalog insulin per sliding scale based on the calculation of blood sugar result minus 100 divided by 30. Subsequent physician's orders, dated 06/01/10, revealed Resident #14 was to receive 16 units of Lantus insulin at supper and to continue the same sliding scale insulin. Continued review of the physician's orders revealed on 09/20/10, the routine Lantus was changed to 12 units in the afternoon. On 10/06/10, routine Lantus was increased to 14 units every day. 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	F 281	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 acknowledged by the facility attending physicians and Medical Director. **Criteria 3:** • 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 3/9/11and 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	

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F 281	Continued From page 16 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 sugars greater than 250 mg/dl. Review of the resident's Diabetic Record from 09/01/10 through 01/13/11 revealed 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. (Refer to F333) 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 the licensed nursing staff should administer medications per the written physician's order. Per interview, a nurse should never alter a medication dosage based on judgement. 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 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 any time there was concern with the administration of any medication and never base administration on nursing judgement without contacting a licensed physician for direction.	F 281	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 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. • 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	

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F 281	Continued From page 17 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 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 which required 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 which identified 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 which involved inaccurate insulin dosage administration were identified as significant medication errors and were reviewed with and acknowledged by the attending physician to discuss the resident's current status and review current insulin orders. No new physician orders were indicated or determined by the physicians.	F 281	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. • 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. **Criteria 4:** • 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 compliance with the facility policies/procedures and MD orders.	

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F 281	Continued From page 18 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. Criteria #3: The facility policy/procedure for Diabetes Management, including management of hyperglycemia was reviewed/revised to address the following: A. Obtaining, interpreting, and reporting of glucose finger sticks 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. 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 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: 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	F 281	• 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. **Criteria 5:**	03/19/11

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F 281	Continued From page 19 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 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. 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: A. Revisions to the Diabetic Management-Hyperglycemia policy. 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. 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: A. The F-157 regulatory requirements for	F 281		

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(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 281	Continued From page 20 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. 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. 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. Criteria #4: Two (2) licensed nursing staff will verify and initial routine and sliding scale insulin	F 281		

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F 281	Continued From page 21 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 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. Criteria #5: March 17, 2011. During the extended survey, on 03/16/11 through 03/18/11, verification of the removal of Immediate Jeopardy was completed as follows: Interviews with Registered Nurse (RN) #1, RN #2,	F 281		

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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 281	Continued From page 22 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 physician if the resident's 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's 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. 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's order. 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	F 281		

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F 281	Continued From page 23 competency checks at the time of review with the process continuing until all licensed nursing staff had been checked off. 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 a review of the test revealed questions pertained to Diabetes, insulin and insulin administration to include questions which required the staff to calculate sliding scale insulin doses. 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 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. 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. 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.	F 281		

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F 281	Continued From page 24 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's 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 281		
F 333	483.25(m)(2) RESIDENTS FREE OF	F 333		

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F 333 SS=K	Continued From page 25 SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure one of fifteen sampled residents (Resident (#14) was free of significant medication errors. The facility failed to ensure policy and procedures related to medication administration were followed. 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. The facility's failure to ensure residents were free from significant medication errors placed residents at risk for imminent danger. The facility was notified, on 03/08/11.	F 333	**483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS** The facility shall ensure that residents are free of any significant medication errors: **Criteria 1:** • Resident #14 no longer resides at the facility. An audit has been completed by the ADON of the Diabetes Management 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. **Criteria 2:** • 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	

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F 333	Continued From page 26 The findings include: A review of the facility's policy entitled, "Medication Administration-General Guidelines," not dated, revealed medications were to be administered as prescribed in accordance with good nursing principles and practices. The procedure portion of the policy revealed medications were to be administered in accordance with written orders of the attending physician. If nursing staff considered a dose excessive, considering the resident's age and/or condition, the nurse was to call the prescriber for clarification. Interviews with Licensed Practical Nurse (LPN) #1 through #9, on 03/08/11 at 10:20 AM, on 03/08/11 at 2:15 PM, on 03/08/11 at 11:15 AM, on 03/07/11 at 4:00 PM, on 03/07/11 at 4:15 PM, on 03/08/11 at 8:45 PM, on 03/08/11 at 9:15 AM, on 03/07/11 at 2:40 PM and on 03/07/11 at 3:00 PM, respectively, revealed the licensed staff routinely altered Resident #14's insulin based on nursing judgement and what each individual nurse felt was best for the resident to maintain an acceptable blood sugar level. The staff interviews revealed they did not contact the physician when altering the resident's dose of insulin. Staff interviews revealed the dose administered was based on such things as food consumption, history, and staff knowledge of the resident. The licensed staff revealed when the glucometer result was "HI", the sliding scale insulin was administered based on the highest reading the glucometer could register. Interview with LPN #2, #4, #5, #7, and #8 revealed if the glucometer registered "HI" the resident's blood sugar would be above 500 milligrams per deciliter (mg/dl). However, based on the manufacture's	F 333	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 acknowledged by the facility attending physicians and Medical Director. **Criteria 3:** • 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	

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F 333	Continued From page 27 instructions a "HI" reading indicated the blood sugar level was greater than 550 mg/dl. Further interview with the licensed staff revealed when the glucometer registered "HI", there was no actual blood sugar reading to calculate the needed dosage of sliding scale insulin. Record review revealed Resident #14 was admitted, on 01/10/08, with diagnoses which included Diabetes Mellitis and Chronic Renal Failure. 1. A review of the physician orders, dated 11/20/09, revealed an order to administer Humalog insulin (fast acting insulin) per sliding scale based on the calculation of the resident's blood sugar results minus 100 divided by 30. Subsequent physician orders, dated 06/01/10, revealed Resident #14 was to receive Lantus insulin (long acting insulin) 16 units at supper and to continue the same sliding scale insulin. Review of the resident's Diabetic Record from 09/01/10 through 09/18/10, and interviews with licensed staff revealed the following significant medication errors: On 09/01/10 at 4:00 PM, Resident #14's accucheck result was 413 mg/dl. LPN #5 did not follow the physician's orders to calculate/identify the amount of sliding scale insulin needed and did not administer any insulin. The resident should have received 10 units of Humalog. On 09/02/10 at 4:00 PM, Resident #14's accucheck result was 470 mg/dl. LPN #2 gave the resident 16 units of Lantus insulin, per the physician's order; however, LPN #2 gave the resident only 5 units of sliding scale Humalog insulin. The nurse should have administered 12	F 333	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 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. • 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	

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F 333	Continued From page 28 units of Humalog regular insulin in accordance with the calculation per the physician's orders. On 09/03/10 at 5:00 AM, Resident #14's accucheck result was 335 mg/dl. LPN #7 administered 5 units of Humalog insulin. In accordance with the calculation per physician order, the LPN should have administered 7 units of Humalog regular insulin. On 09/03/10 at 4:00 PM, Resident #14's accucheck result was 386 mg/dl. LPN #5 administered the resident's Lantus insulin per physician's orders and did not administer any sliding scale Humalog insulin. LPN #5 should have administered 9 units of Humalog regular insulin per the ordered calculation. On 09/04/10 at 2:30 AM, Resident #14's accucheck result was 440 mg/dl. LPN #7 administered 8 units of Humalog insulin. In accordance with the ordered calculation, LPN #7 should have administered 11 units of Humalog regular insulin. On 09/04/10 at 5:00 AM, Resident #14's accucheck result was 218 mg/dl. LPN #7 administered 10 units of Humalog insulin. In accordance with physician's orders, no sliding scale Humalog insulin should have been administered. Additionally, LPN #7 administered 16 units of Lantus insulin which was not ordered to be administered at 5:00 AM. On 09/06/10 at 4:00 PM, Resident #14's accucheck result was "HI", which indicated the result was above 550 mg/dl and the actual results could not be determined per the glucometer. LPN #2 administered 16 units of Lantus insulin	F 333	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. • 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 3/17/11. **Criteria 4:** • 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	

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F 333	Continued From page 29 and 10 units of Humalog insulin. However, due to the "HI" glucometer result, the resident's actual blood sugar was not determined and the resident's needed dosage of Humalog insulin could not be calculated. On 09/07/10 at 4:00 PM. Resident #14's accucheck result was 236 mg/dl. LPN #6 administered 8 units of Lantus insulin. In accordance with physician's order's LPN #6 should have administered 16 units of Lantus insulin. On 09/08/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #5 administered 8 units of Lantus insulin and 5 units of sliding scale Humalog insulin. However, per the physician's orders LPN #5 should have administered 16 units of Lantus insulin. Due to the "HI" glucometer result, Resident #14's actual blood sugar was undetermined and the resident's needed dosage of Humalog insulin could not be calculated. On 09/09/10 at 5:00 AM, Resident #14's accucheck result was 449 mg/dl. LPN #7 administered 6 units of Humalog insulin. In accordance with the ordered calculation, LPN #7 should have administered 11 units of Humalog insulin. On 09/09/10 at 4:00 PM, Resident #14's accucheck result was 419 mg/dl. LPN #14 administered 16 units of Lantus insulin and 6 units of sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #14 should have administered 10 units of Humalog insulin.	F 333	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 compliance with the facility policies/procedures and MD orders. • 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. **Criteria 5:**	03/19/11

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F 333	Continued From page 30 On 09/10/10 at 4:00 PM, Resident #14's accucheck result was 467 mg/dl. LPN #2 administered 16 units of Lantus insulin and 5 units of the sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #2 should have administered 12 units of Humalog insulin. On 09/12/10 at 4:00 PM, Resident #14's accucheck result was 184 mg/dl. LPN #4 withheld 16 units of Lantus insulin, without consultation with the resident's physician. LPN #4 should have administered 16 units of Lantus insulin as ordered. On 09/13/10 at 4:00 PM, Resident #14's accucheck result was "HI". An unidentified LPN administered 16 units of Lantus insulin and 10 units of the sliding scale Humalog insulin. Resident #14's blood sugar result was undetermined and therefore, the amount of Humalog insulin needed could not be calculated as ordered. On 09/15/10 at 4:00 PM, Resident #14's accucheck result was "HI". LPN #5 administered 16 units of Lantus insulin and 10 units of sliding scale Humalog insulin. Resident #14's blood sugar result was undetermined and therefore, could not be calculated as ordered. On 09/16/10 at 4:00 PM, Resident #14's accucheck result was 468 mg/dl. LPN #2 administered 16 units of Lantus insulin and 5 units of sliding scale Humalog insulin. In accordance with the ordered calculation, LPN #2 should have administered 12 units of Humalog insulin.	F 333		