

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

PRINTED: 11/20/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445339	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/11/2009
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NAME OF PROVIDER OR SUPPLIER BAILEY PARK CLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 MITCHELL STREET HUMBOLDT, TN 38343
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F 000	<p>INITIAL COMMENTS</p> <p>An annual re-certification survey was conducted from Sunday, 11/8/09 through Wednesday, 11/11/09. An entrance conference was conducted with the Administrator and Nurse Consultant, in the Administrator's office, on 11/8/09 at 9:40 AM. A conference was held in the conference room on 11/10/09 at 4:45 PM, at which time the Administrator and Director of Nursing (DON) were informed of the findings that are, or are likely to place diabetic residents in a serious and immediate threat to their health. The insulin dependent diabetics have the high likelihood of having hypo/hyperglycemic episodes by receiving the wrong insulin or the wrong insulin doses. The exit conference was conducted in the conference room on 11/11/09 at 10:30 AM, with the Administrator, Director of Nursing, Medical Records, Dietary Manager, Nurse Consultant, Pharmacy Consultant, Minimum Data Set Coordinator, Maintenance and other staff. The facility was informed of the survey team findings and that this would be an Immediate Jeopardy (IJ).</p> <p>The facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure that physician's were notified in a timely manner of residents' elevated and low blood sugars. 2. Ensure the care plan was followed for monitoring/recording blood/glucose levels and/or administering medications. 3. Ensure insulin was administered in a timely manner in relation to a meal, ensure correct doses of insulin were administered, ensure the correct type of insulin was administered in 	F 000	<p>This Plan of Correction is being submitted as required by Federal regulation. The submission of this plan of correction is not to be construed as an admission by the facility as to the accuracy of the citation nor the findings of facts. Please accept this as our plan of correction.</p> <p>Abbreviations Adm- Administrator DON- Director of Nursing IDT- Interdisciplinary Team MAR- Medication Administration Record MD- Medical Doctor MDS- Minimum Data Set NC- Nurse Consultant QA- Quality Assurance Res- Resident RN- Registered Nurse SSI- Sliding Scale Insulin</p>	
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Accepted by 12/11/09 SP PH/ML

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Betty Mullins, Adm</i>	TITLE Adm	(X6) DATE 11-25-09
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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 000	Continued From page 1 accordance with physician's orders or ensure orders were obtained for insulin administration (There was incomplete sliding scale insulin orders for a resident, when there was no insulin order for coverage of blood glucose level ranging from 401 to (-) 449 and/or 401-450. 4. Ensure the Consulting Pharmacist monitored, reviewed and identified that medications were administered correctly, that fast acting insulin was administered correctly, that there were no blanks on the Medication Administration Record (MAR) and that medications were available for the residents as ordered by the physician. 5. Ensure that an effective and efficient Quality Assurance program identified, monitored and followed up on quality of care issues such as notifying the physician of high and low blood sugars/glucoses; problems with insulin not being administered as ordered or ensuring orders were obtained for insulin administration. 6. Ensure that medical records are complete and have accurate documentation.	F 000		
F 157 SS=J	The IJ effective date is 11/10/09, and is ongoing until the IJ is removed. The cited tag of F333 at a scope and severity of J is a Substandard Quality of Care citation. 483.10(b)(11) NOTIFICATION OF CHANGES 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	F 157	F157 Notification of changes 1. The physicians for Residents 14 , 15, and 16 were notified of the blood glucose results for October and November on 11/20/09 by the Nurse consultant, RN.	11-20-09

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F 157	<p>Continued From page 2</p> <p>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).</p> <p>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.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and interviews, it was determined the facility failed to ensure the physician was notified of low and elevated blood glucose (BG) levels for 3 of 8 (Residents #14, 15 and 16) sampled residents that the facility had identified and documented as being insulin dependent. The failure to notify the physician of blood glucoses below 50 and above 450, placed all diabetic residents in conditions that are likely to be a serious and immediate threat to their health. A conference was held in the conference room on 11/10/09 at 4:45 PM, at</p>	F 157	<p>On 11/24/09, the NC, RN and the DON verified with the physician for Res 14 that he was aware on 11/20/09 for blood sugars on Resident 14 for months of March, August, June, September 2009 and the HGB AIC results of June and September 2009, and the wrong insulin administered and no MD SSI order for range 401-450 during August and September.</p> <p>On 11/24/09 the NC, RN and the DON verified with the Physician for Resident 15 that he was aware on 11/20/09 for blood sugars on Res 15 for months of August and September 2009.</p> <p>2. Other resident's with the potential to be affected were identified by a review of the blood glucoses for the past month of diabetic residents by Director of Nursing and the Nurse Consultant on 11/11/09. Findings from the review were lack of notification parameters and inadequate insulin orders. The physicians were notified</p>	
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F 157	<p>Continued From page 3</p> <p>which time the Administrator and Director of Nursing (DON) were informed of the findings that are, or are likely to place diabetic residents in a serious and immediate threat to their health which resulted in an Immediate Jeopardy (IJ). The IJ effective date is 11/10/09, and is ongoing until the IJ is removed.</p> <p>The findings included:</p> <p>1. Review of the facility's "Changes in a Resident's Condition or Status" policy documented; "...It is the policy of this facility...to notify the...attending physician ...of changes in the resident's condition and/or status... Procedure 1. Nursing services shall be responsible for notifying the resident's attending physician when ...b. There is a significant change in the resident's physical, mental or emotional status... d. There is a need to alter the resident's treatment significantly... 4. All notifications must be made as soon as practical, but in no case shall such notification exceed twenty-four (24) hours. 5. All changes in the resident's medical condition must be properly recorded in the resident's medical record..."</p> <p>Review of the facility's "Diabetic Therapeutic Protocol" policy documented, "The physician must approve the use of the Diabetic Therapeutic Protocol for each of her/his use and write a corresponding order in the medical record. Nurses will be informed of this protocol upon hire and regularly thereafter. Hypoglycemia Protocol If the resident is asymptomatic, alert, and the finger stick blood glucose is less than 50 (or as indicated by the physician)...4. Notify the physician. The physician is notified even if the resident improves...Hyperglycemia Protocol If the</p>	F 157	<p>as needed by the DON and/or NC for new orders. This review included all diabetics. The primary nurse for the resident will be responsible for notification of the physician going forward.</p> <p>3. Licensed nursing staff was in serviced on 11/14/09 regarding reporting changes in the resident's condition to the physician by the NC, RN. The diabetic therapeutic protocol in-service was done by the Director of Nursing and the Adm. on 11/10/09, 100 % licensed nursing attendance.</p> <p>Nurses not in serviced on this date will be in serviced prior to returning to duty . No agency nurses are utilized at this time. In-service will be conducted upon hire and annually thereafter. Agency nurses will be in serviced prior to working. These in-services will be conducted by the Director of Nursing or the RN supervisor.</p>	
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F 157	<p>Continued From page 4</p> <p>resident is alert, asymptomatic, and a finger stick blood glucose is greater than 450 (or as indicated by the physician): 1. If sliding scale insulin is ordered, give the ordered dose. 2. Recheck the finger stick blood glucose in 10 min [minutes]. If no improvement in the finger stick glucose, notify the physician. 3. If no sliding scale insulin is ordered, notify the physician."</p> <p>Review of the facility's "Accucheck/Diabetic Policy and Procedure" documented, "It is the policy of the facility to perform Accuchecks and administer insulin as ordered by the resident's attending physician. Procedure 1. Accuchecks will be performed as ordered by the physician. 2. The physician will be notified of Accucheck results not within parameters set by the physician..."</p> <p>2. The surveyors attempted to contact the Medical Director on 11/11/09. The Medical Director returned the call to the state office on 11/12/09 at 10:15 AM. The Medical Director, who is the attending physician for Resident #14, was asked when he would expect to be notified of blood glucose (BG) levels. The Medical Director stated, "...Certainly if it's greater than 400 or 450 they [staff] need to notify me... if below 60 notify me..." The Medical Director was asked if he reviewed the residents' BG flow sheets. The Medical Director stated, "...I review the [Hemoglobin] A1C [a laboratory blood glucose test that averages blood glucose for 3 months] ...not the flow sheets...The flow sheet is more for nursing..." The Medical Director confirmed that he was not aware of any problems with blood sugars until 11/11/09 and had not been invited to a Quality Assurance (QA) meeting in 4 to 5 months due to the recent changes in administration.</p>	F 157	<p>The existing Diabetic therapeutic protocol was re-instated on 11/20/09 to set parameters for physician notification of blood glucoses.</p> <p>4. An audit tool to check the blood glucose levels and verify physician notification was developed by NC, RN on 11/10/09 The Director of Nursing or RN supervisor will audit diabetic records daily for 4 weeks to ensure compliance, then monthly for one month and the quarterly for the next 12 months. The results of the audits will be reported to the QA committee weekly for 4 weeks and then monthly for 1 month and then quarterly for the next 12 months. The QA committee, comprised of the Administrator, the Director of Nursing, the Medical Director, Dietician /food service manager, the Pharmacy Consultant, the Social Services director, the</p>		

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F 157	<p>Continued From page 5</p> <p>Medical record review for Resident #14 documented an admission date of 2/26/09 with diagnoses of Mood Disorder, Benign Prostate Hypertrophy, Suicidal Ideation, Diabetic Retinopathy, Gastroesophageal Reflux Disease, Hypertension and Diabetes Mellitus. A telephone order dated 2/26/09 documented "... Fax BG [blood glucose] to office on 3-5-09..." Review of the physician's admission orders dated 2/27/09 documented "...Accuchecks ac [before meals] & [and] hs... 6AM... 11AM... 4PM... 9PM..." Review of the admission progress note dated 2/27/09 documented "...PMH [past medical history]... DM [Diabetes Mellitus], out of control..." The facility's protocol was for the MD to be notified of blood glucoses below 50 and above 450. There was no physician order written that was different from this parameter.</p> <p>Review of Resident 14's laboratory BG dated 3/6/09 documented "Test>Glucose, Result=35, Flag *L [alert to low BG value], Reference [Ranges within normal limits] =75-110." There was no documentation the Medical Director (MD) was notified of this low BG.</p> <p>Review of Resident #14's Blood Glucose (BG) flow sheet for March 2009 documented the following BG results with no documentation that the physician was notified:</p> <ul style="list-style-type: none"> a. 3/8/09 at 9:00 PM - BG was (=) 54. b. 3/11/09 at 2:30 PM - BG = 496. c. 3/11/09 at 4:30 PM - BG = 493. d. 3/12/09 at 8:30 PM - BG = 404. e. 3/13/09 at 5:00 PM - BG = 433. f. 3/13/09 at 9:00 PM - BG = 532. g. 3/14/09 at 3:00 PM - BG = 510. h. 3/15/09 at 4:00 PM - BG = 445. i. 3/15/09 at 8:00 PM - BG = 541. 	F 157	<p>Activity director, the environmental services director, the MDS coordinator, and others as appointed by the administrator, will make any needed changes to the plan .</p>	
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F 157	<p>Continued From page 6</p> <p>j. 3/26/09 at 9:00 PM - BG = 481. k. 3/27/09 at 4:00 PM - BG = 450. l. 3/29/09 at 9:00 PM - BG = 466. m. 3/30/09 at 8:00 PM - BG = 423.</p> <p>Review of Resident 14's laboratory HGB A1C dated 6/30/09 documented "Test>HGB A1C, Result=8.9, Flag H [High A1C level], Reference=< [below] 7.0% [percent]." There was no documentation the MD was notified of this high level HGB A1C.</p> <p>Review of Resident #14's physician's orders dated 8/1/09 documented "...ACCUCHECK AC AND HS SS [sliding scale] NOVLOG INSULIN... 150- [to] 200 4U [units] ...201-250 6U...251-300 8U...301-350 10U...351-400 15U... 451-14U AND MONITOR Q [every] 4 HRS [hours] TIL [until] STABLE..." There was no physician's order for sliding scale insulin to be given for BG readings for 401 to 499. The physician was not notified to obtain SSI orders for BG for 401-450 as per the facility's diabetic therapeutic protocol.</p> <p>Review of Resident #14's BG flow sheets for August 2009 documented the following:</p> <p>a. 8/4/09 at 4:00 PM - BG = 416, 14U of Novolog insulin given. There was no documentation that the physician was notified of the BG, nor was an order obtained for the insulin administered.</p> <p>b. 8/6/09 at 4:00 PM - BG = 404, 15U of Novolog insulin given. There was no documentation that the physician was notified of the BG, nor was an order obtained for the insulin administered.</p> <p>c. 8/14/09 at 4:00 PM - BG = 507, there was no documentation that the physician was notified of the 507 BG. There was another BG documented on 8/14/09 at 4:00 PM - BG = 448, 15U of Humalog given. There was no documentation that</p>	F 157		
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F 157	<p>Continued From page 7</p> <p>the physician was notified of the BG, nor was an order obtained for the insulin administered.</p> <p>d. 8/14/089 at 8:00 PM - BG = 58, there was no documentation that the physician was notified of the BG.</p> <p>e. 8/17/09 at 4:00 PM - BG = 474, there was no documentation that the physician was notified of the BG.</p> <p>f. 8/19/09 at 4:00 PM - BG = 424, 15U of Novolog given. There was no documentation that the physician was notified of the BG, nor was an order obtained for the insulin administered.</p> <p>g. 8/20/09 at 11:00 AM - BG = 517. There was no documentation that the physician was notified of the BG.</p> <p>h. 8/21/09 at 4:00 PM - BG = 410, 15U of Novolog given. There was no documentation that the physician was notified of the BG, nor was an order obtained for the insulin administered.</p> <p>i. 8/24/09 at 4:00 PM - BG = 445, 15U of Novolog given. There was no documentation that the physician was notified of the BG, nor was an order obtained for the insulin administered.</p> <p>j. 8/29/09 at 11:00 AM - BG = 457. There was no documentation that the physician was notified of the BG.</p> <p>Review of Resident #14's physician's recertification orders for September 2009 documented the same insulin orders as August 2009. Review of Resident #14's MAR for September 2009 documented that Levimir 25 units was given at 8:00 PM from 9/1/09 through 9/11/09 without a physician's order. Review of Resident #14's BG flow sheet for September 2009 documented 120 opportunities for the BG to be checked. The BG ranged from a high of 467 on 9/23/09 at 4:00 PM to a low of 62 on 9/8/09 at 11:00 AM. The BG on 9/23/09 at 4:00 PM was</p>	F 157		
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F 157	<p>Continued From page 8</p> <p>467. There was no documentation that the physician was notified of this elevated BG.</p> <p>Review of Resident 14's laboratory HGB A1C dated 9/30/09 documented "Test>HGB A1C, Result=8.2, Flag H [High A1C level], Reference=4.2-5.8. It was documented on the laboratory results form, "Faxed to DR [Doctor] 10/6/09 @ [at] 3:15 PM" (6 days after the result was received). There was no documentation the MD was notified timely of the high HGB A1C level.</p> <p>During an interview in the conference room on 11/10/09 at 2:35 PM, the Director of Nurses (DON) was asked would she expect the nurses to notify the physician of a blood glucose over 500. The DON stated, "Uh...Yeah...They should notify the Doctor..."</p> <p>3. Medical record review for Resident #15 documented an admission date of 7/10/09 with diagnoses of Diabetes, Hypertension, Tobacco Use Disorder and Below knee Amputation. Review of a physician's order dated 8/12/09 and 9/1/09 documented, "REGULAR CONSISTENT CARB [Carbohydrate] DIET...ACCU CHECK AC [before meals] /HS W [WITH] NOVOLIN R SS [SLIDING SCALE] COVERAGE 0-60 = 4oz [ounces] OJ [orange juice] 61-150 = NO COVERAGE, 151-200 = 2U, 201-250 = 4U, 251-300 = 6U, GREATER THAN 300 = 8U..." The facility's protocol was for the MD to be notified of blood glucoses below 50 and above 450. There was no physician order written that was different from this parameter.</p> <p>Review of Resident #15's August 2009 MAR and patient record log documented a BG of 40 on</p>	F 157		
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F 157	<p>Continued From page 9</p> <p>8/4/09 at 4:30 PM. Review of the August 2009 MAR documented actions taken as "ate dinner with sweets" rechecked BG at 5:30 PM, BG was 116. There was no documentation that the physician was notified of the low BG of 40.</p> <p>Review of Resident #15's September 2009 MAR and patient record log/request for treatment plan documented a BG of 45 on 9/28/09 at 6:30 AM, apple juice given. A rechecked BG of 84 on 9/28/09 at 6:45 AM. There was no documentation that the physician was notified of the low BG of 45.</p> <p>4. Medical record review for Resident #16 documented an admission date of 10/23/09 with diagnoses of Diabetes, Ankle Fracture, Morbid Obesity, Hypertension, Parkinson's Disease, General Anxiety, Depression, Chronic Obstructive Pulmonary Disease and Obstructive Sleep Apnea. Review of the physician's orders dated 11/3/09 documented, "Lantus 6 Units SQ [subcutaneous] at HS...Accucheck AC and HS c SS R [regular] insulin 201- 250 =3U, 251-300 =6U, 301 -350 = 9U, 351 - 400 = 12U, > [greater than] 400 = 12U and recheck in 1 hour..." The facility's protocol was for the MD to be notified of blood glucoses below 50 and above 450. There was no physician order written that was different from this parameter.</p> <p>Review of Resident #16's November 2009 MAR and patient record log/request for treatment plan documented a BG of 49 on 11/8/09 at 6:00 AM, kool-aid given. There was no documentation that the BG was rechecked or that the physician was notified of the low BG of 49.</p> <p>5. The surveyors attempted to contact the</p>	F 157		
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NAME OF PROVIDER OR SUPPLIER BAILEY PARK CLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 MITCHELL STREET HUMBOLDT, TN 38343
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F 157	Continued From page 10 Physician for Resident #15 and #16 on 11/11/09. The Resident #15 and #16's Physician returned the call to the state office on 11/12/09 at 4:40 PM. Resident #15 and 16's attending Physician verified that he was not aware of any problems with insulin regarding his residents in recent times.	F 157		
F 164 SS=D	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	F 164 1. The MAR was closed upon discovery. Nurse # 3 has been re-educated by the NC on 11/11/09 on maintaining the confidentiality of residents' records by closing the MAR during med pass. 2. Other residents having the potential to be affected were identified by observation of med passes by the DON, NC, and Pharmacy Consultant on 11/14/09 3. The licensed nursing staff was in serviced on 11/14/09 by the DON regarding maintaining the confidentiality of residents' records by closing the MAR during med pass.	11-25-09

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Nurses not in serviced on this date will be in serviced prior to returning to duty . No agency nurses are utilized at this time. In-service will be conducted upon hire and annually thereafter. Agency nurses will be in serviced prior to working. These in-services will be conducted by the Director of Nursing or the RN supervisor.

The Medication Pass Evaluation Tool was created by the DON on 11/14/09 to audit privacy of Mars. The tool includes observation of the nurse being evaluated closing the MAR when not in use. The DON/NC began the Medication Pass Evaluation with nurses on 11/14/09.

4. The Director of Nursing and NC began the Medication Pass Evaluation with all nurses 11/14/09 and will continue until all nurses have been completed. The DON or the RN supervisor will observe a

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med pass with 2 nurses 2 times
 a week for 4 weeks the 2
 nurses weekly for 2 months
 and then 2 nurses quarterly for
 the next 12 months. Findings
 of the audit will be reported to
 the QA committee weekly for
 4 weeks, monthly for 2
 months, and then quarterly for
 the next 12 months. and then
 as needed. The QA committee,
 comprised of the
 Administrator, the Director of
 Nursing, the Medical Director,
 Dietician /food service
 manager, the Pharmacy
 Consultant, the Social Services
 director, the Activity director,
 the environmental services
 director, the MDS coordinator,
 and others as appointed by the
 administrator, will make any
 needed changes to the plan .

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F 164	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observations, it was determined 1 of 7 (Nurse #3) nurses failed to maintain the confidentiality of residents' medical records by not covering or closing the Medication Administration Record (MAR) during medication administration. The findings included: 1. Observations outside of resident room 304 on 11/9/09 at 3:25 PM, Nurse #3 left the MAR open, on the medication cart, revealing the resident's private information. 2. Observations outside of resident room 303 on 11/9/09 at 3:35 PM, Nurse #3 left the MAR open, on the medication cart, revealing the resident's private information. 483.15(a) DIGNITY	F 164		
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F 241 SS=D	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on policy review, observations and interview, it was determined 2 of 6 (Nurses #3 and 6) nurses failed to maintained residents' dignity and respect by entering residents' rooms without knocking or gaining permission prior to entering the room during the medication pass. The findings included: 1. Review of the facility's Resident Rights policy	F 241	1. Nurses #3 and #6 were re-educated by the DON and the NC on 11/14/09 on resident privacy in regard to knocking on doors and gaining permission prior to entering . 2. Other residents with the potential to be affected were identified through observation of staff entering rooms on 11/14/09. Staff were verbally re-educated by the ADM, DON, and/or NC at the time of the observation	11-26-09
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F 241 Continued From page 12
 documented, "It is the policy of the facility that all residents be treated with kindness, dignity, and respect. Staff members shall knock before entering the resident's room."
 2. Observations during the medication pass on 11/9/09 at 3:20 PM, Nurse #3 entered resident room 109 B without knocking or gaining permission to enter.
 Observations during the medication pass on 11/9/09 at 3:27 PM, Nurse #3 entered resident room 302 B without knocking or gaining permission to enter.
 Observations during the medication pass on 11/9/09 at 3:30 PM, Nurse #3 entered resident room 302 A without knocking or gaining permission to enter.
 2. Observations during the medication pass on 11/10/09 at 5:15 AM, Nurse #6 entered into room 205 without knocking or gaining permission to enter.
 Observations during the medication pass on 11/10/09 at 6:10 AM, Nurse #6 entered resident room 206 without knocking or gaining permission to enter.
 During an interview in the hallway outside room 206 on 11/10/09 at 6:15 AM, (after the surveyor knocked on the door) Nurse #6 stated, "I always forget to do that [knock on the door] when the door is open."

F 241

3. All laundry, housekeeping, social, dietary, activity, nursing and administrative staff were in serviced on privacy regarding knocking on doors and gaining permission to enter on 11/14/09 by the administrator. Education on Resident Rights will be provided upon hire and annually thereafter for laundry, housekeeping, social, dietary, activity, nursing and administrative staff.
 A Resident Privacy Audit Tool was created. was created by the DON on 11/13/09 and involves visual observation of knocking on doors, privacy curtains, MAR s closed.

4. The Resident Privacy Audit Tool will be completed by the Social Service Director, the DON, the ADM, or NC every day for 2 weeks, then weekly for 4 weeks and then monthly for the next 12 months. The results of the audits will be reported to the QA committee weekly for 4 weeks and then monthly for the next 12 months. The QA committee, comprised of the Administrator, the Director of Nursing, the Medical Director, Dietician /food service manager, the Pharmacy Consultant, the Social Services director, the Activity director, the environmental services director, the MDS coordinator, and others as appointed by the administrator, will make any needed changes to the plan. will make any needed changes to the plan

F 258
SS=D

483.15(h)(7) ENVIRONMENT- SOUND LEVELS
 The facility must provide for the maintenance of comfortable sound levels.

F 258

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F 258	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observations and the group interview, it was determined the facility failed to maintain comfortable sound levels on 1 of 4 (200 hall) halls in the facility. Six (6) of 9 alert and oriented residents (Resident #9 and Random Residents (RR) #1, 6, 7, 8 and 9) attending the group interview complained of loud noises during the night and early morning hours. The findings included: During the group interview conducted in the parlor room on 11/9/09 at 9:00 AM, sampled Resident #9 and RRs #1, 6, 7, 8 and 9 complained of the noise during the night and early morning hours related to the laundry barrels being rolled down the halls. Observations in the 200 Hall on 11/10/09 at 5:24 AM and 6:15 AM, revealed laundry barrels being transported from the laundry hallway to the 200 hallway making a very loud noise.	F 258	F258 1. The Activity Director and ADM held a Resident Council on 11/14/09 to identify the issues with noise control. The Activity Director and Social Services Director interviewed the residents not attending the Resident council meeting to identify issue with noise control on 11/25/09 2. All residents having the potential to be affected were identified through resident council and one on one interviews by the AD and SS on 11/25/09. 3. The barrels were insulated to decrease the amount of noise . Another resident council meeting was held 11/19/09 to inform the residents of the measures in place A Noise Level in Hallway Audit tool was created by the Adm on 11/19/09/ to document noise levels	11/25/09
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.			

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F 258	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observations and the group interview, it was determined the facility failed to maintain comfortable sound levels on 1 of 4 (200 hall) halls in the facility. Six (6) of 9 alert and oriented residents (Resident #9 and Random Residents (RR) #1, 6, 7, 8 and 9) attending the group interview complained of loud noises during the night and early morning hours. The findings included: During the group interview conducted in the parlor room on 11/9/09 at 9:00 AM, sampled Resident #9 and RRs #1, 6, 7, 8 and 9 complained of the noise during the night and early morning hours related to the laundry barrels being rolled down the halls. Observations in the 200 Hall on 11/10/09 at 5:24 AM and 6:15 AM, revealed laundry barrels being transported from the laundry hallway to the 200 hallway making a very loud noise.	F 258	4. The Activity Director will discuss noise level during monthly resident council meeting once a month for 1 month and then quarterly for the next 12 months. The Activity Director will interview one resident on each hallway once a month for 1 month and then quarterly for the next 12 months. The findings will be presented to the QA committee monthly for 1 month and then quarterly for the next 12 months. The Administrator Maintenance Director will make walking round daily for one week, then weekly x 4, then monthly x 3, then quarterly for the next 12 months to cover all shifts to assess noise levels. The findings of these rounds will be presented to the QA committee weekly for 4 weeks, then monthly for 3 months and then quarterly for the next 12 months. The QA committee The QA committee, comprised of the Administrator, the Director of Nursing, the Medical Director, Dietician /food service manager, the Pharmacy Consultant, the Social Services director, the Activity director, the		
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.				

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F 258	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and the group interview, it was determined the facility failed to maintain comfortable sound levels on 1 of 4 (200 hall) halls in the facility. Six (6) of 9 alert and oriented residents (Resident #9 and Random Residents (RR) #1, 6, 7, 8 and 9) attending the group interview complained of loud noises during the night and early morning hours.</p> <p>The findings included: During the group interview conducted in the parlor room on 11/9/09 at 9:00 AM, sampled Resident #9 and RRs #1, 6, 7, 8 and 9 complained of the noise during the night and early morning hours related to the laundry barrels being rolled down the halls.</p> <p>Observations in the 200 Hall on 11/10/09 at 5:24 AM and 6:15 AM, revealed laundry barrels being transported from the laundry hallway to the 200 hallway making a very loud noise.</p>	F 258	<p>environmental services director, the MDS coordinator, and others as appointed by the administrator, will make any needed changes to the plan.</p>	
F 278 SS=D	<p>483.20(g) - (j) RESIDENT ASSESSMENT</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p>	F 278	<p>F 278</p> <p>1. The MDS for Resident #3 was reviewed by the NC and a significant change assessment was completed on 11/22/09 by the MDS nurse due to changes in wound staging. Resident #9's MDS was reviewed by the NC for accuracy and MDS attestation done by MDS nurse on 11/22/09 to correct data entry error related to dialysis.</p>	11-25-09

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F 278 Continued From page 14
 Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

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

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
 Based on medical record review and interview, it was determined the facility failed to accurately complete the Minimum Data Set (MDS) for 2 of 18 (Residents #3 and 9) sampled residents.

The findings included:

1. Medical record review for Resident #3 documented an admission date of 8/31/09 with diagnoses of Acute Kidney Failure, Gastrointestinal Stromal Tumor, Pressure Ulcers, Colostomy, Left Above Knee Amputation and Sepsis. Review of the MDS dated 9/4/09 documented in "Section M. Skin Condition 1... a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved... 3 areas ...b... Stage 2. A partial thickness loss of skin

F 278

2. Other residents with the potential to be affected were identified by a review of the current MDS by the NC on 11/21/09 for each resident receiving dialysis and no corrections were needed. No other residents were identified with pressure ulcers.
3. The MDS nurse was re-educated by the DON on 11/20/09 regarding accurate completion of the MDS. The Director of nursing will review 2 MDS for accuracy each month for the next 12 months. An MDS audit tool was created by the NC on 11/20/09. The tool will track any changes needed and supporting documentation.
4. The findings of the MDS review will be reported by the DON to the QA

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F 278	Continued From page 15 layers that presents clinically as an abrasion, blister or shallow crater... 3 areas." The MDS dated 10/30/09 documented in "Section M. Skin Condition 1... a. Stage 1... 1 area ... b... Stage 2... 2 areas." The facility failed to accurately assess the resident for pressure ulcers. Review of the weekly ulcer reports dated 9/4/09 and 10/30/09 documented 2 pressure ulcers at a stage 3. 2. Medical record review for Resident #9 documented an admission date of 1/28/09 and a readmission date of 3/30/09 with diagnoses of Lower Extremity Embolism, Muscle Disuse Atrophy, End Stage Renal Disease, Malignant Hypertension, and Diabetes with Renal Manifest. The MDS dated 4/30/09 in "Section P 1 b" dialysis was not documented. The facility failed to accurately complete the MDS. During an interview in the conference room on 11/11/09 at 8:20 AM, the MDS Nurse stated, "I pull information from the admission nurse assessment, skin book, and look at the treatment sheets...there is so much information it is hard for me to gather...I look at the residents myself..." 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS	F 278	committee monthly for 3 months and then quarterly for the next 12 months. The QA committee, comprised of the Administrator, the Director of Nursing, the Medical Director, Dietician /food service manager, the Pharmacy Consultant, the Social Services director, the Activity director, the environmental services director, the MDS coordinator, and others as appointed by the administrator, will make any needed changes to the plan .	
F 280 SS=D	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280	F280 1. The care plan for Resident # 9 has been revised to include emergency measures for bleeding by the NC on 11/22/09 . 2. One other resident receiving dialysis was identified as having the potential to be affected. The care plan was reviewed by the NC and changes made 11/12/09.	11-25-09

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STREET ADDRESS, CITY, STATE, ZIP CODE

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 for the resident, and other appropriate staff in
 disciplines as determined by the resident's needs,
 and, to the extent practicable, the participation of
 the resident, the resident's family or the resident's
 legal representative; and periodically reviewed
 and revised by a team of qualified persons after
 each assessment.

This REQUIREMENT is not met as evidenced
 by:
 Based on medical record review, observation and
 interview, it was determined the facility failed to
 revise the resident care plan for emergency
 bleeding for 1 of 18 (Resident #9) sampled
 residents.

The findings included:

Medical record review for Resident #9
 documented an admission date of 1/28/09 and a
 readmission date of 3/30/09 with diagnoses of
 Lower Extremity Embolism, End Stage Renal
 Disease, Diabetes with Renal Manifest and
 Muscle Disuse Atrophy. Review of the
 comprehensive care plan had no documentation
 for care of emergency bleeding related to
 Resident #9 having a Left Subclavian Port access
 for dialysis.

During an observation and interview with
 Resident #9 in her room on 11/9/09 at 3:45 PM,
 Resident #9 was lying in bed covered up.
 Resident #9 invited the surveyor into her room
 and told the surveyor she had been to dialysis
 today. The surveyor asked Resident #9 if she had
 a shunt. Resident #9 stated, "No, I have a port."

F 280

3. The IDT care plan team
 including the MDS nurse, AD,
 SS, and Dietary Director were in
 serviced by the NC on 11/22/09
 regarding comprehensive care
 plans for emergent bleeding from
 dialysis access devices.
 A care plan audit tool was created
 by the NC on 11/12/09. The tool
 reflects the care plan is
 individualized and
 implementation reflected in the
 nurses notes.

4. The Director of Nursing or the
 Medical Records nurse will check
 2 care plans a week for 4 weeks
 then 2 care plans a month for 2
 months and then quarterly for the
 next 12 months and report finding
 to the QA committee monthly for
 3 months and then quarterly for
 the next 12 months.
 The QA committee, comprised of
 the Administrator, the Director of
 Nursing, the Medical Director,
 Dietician /food service manager,
 the Pharmacy Consultant, the
 Social Services director, the
 Activity director, the
 environmental services director,
 the MDS coordinator, and others
 as appointed by the administrator,

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IDENTIFICATION NUMBER:

445339

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

11/11/2009

NAME OF PROVIDER OR SUPPLIER

BAILEY PARK CLC

STREET ADDRESS, CITY, STATE, ZIP CODE

2400 MITCHELL STREET
HUMBOLDT, TN 38343

(X4) ID
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F 280

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and patted her upper chest.

F 280

will make any needed changes to
the plan . will make any needed
changes to the plan.

F 282

SS=J

483.20(k)(3)(ii) COMPREHENSIVE CARE
PLANS

F 282

F282

The services provided or arranged by the facility
must be provided by qualified persons in
accordance with each resident's written plan of
care.

1. The care plans for Residents
4,14,15, and 16 are now being
followed regarding monitoring
and recording blood/glucose
levels and/or administering
medications as ordered. The care
plans were reviewed by the DON
and NC, RN on 11/11/09.

This REQUIREMENT is not met as evidenced
by:
Based on policy review, review of "MED-PASS"
provided by the American Society of Consultant
Pharmacists, medical record review, observation
and interview, it was determined the facility staff
failed to follow the comprehensive care plan for
monitoring/recording blood/glucose levels and/or
administering medications as ordered for 4 of 18
(Residents #4, 14, 15 and 16) sampled residents.
The insulin dependent diabetic residents have the
high likelihood of having hypo/hyperglycemic
episodes by receiving the wrong insulin or the
wrong insulin doses. A conference was held in
the conference room on 11/10/09 at 4:45 PM, at
which time the Administrator and Director of
Nursing (DON) were informed of the findings that
placed the diabetic residents in immediate
jeopardy (IJ). The IJ effective date is 11/10/09,
and is ongoing until the IJ is removed.

2. Residents with the potential to
be affected were identified by a
review of the physician orders,
MARs, care plans, and diabetic
records for all diabetic residents
was begun on 11/11/09 and
completed on 11/19/09 by the
DON, the ADM, and the NC,RN.
Findings were lack of notification
parameters for blood glucoses,
inadequate physician orders for
SSI and insulin.

11-20-09

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Continued From page 18

The findings included:

1. Medical record review for Resident #4 documented an admission date of 2/26/09 and a readmission date of 10/1/09 with diagnoses of Diabetes, Aphasia, Hypertension, Convulsions, Stroke with Hemiparesis and Dementia. Review of the care plan dated 2/26/09 and updated 6/4/09 and 9/2/09 documented, "Accu-checks as ordered per MD [Medical Doctor] Administer medications as ordered per MD assess for s/s [signs and symptoms] for hypo / hyperglycemia..." Review of Resident #4's August 2009 physician's order documented, "...NOVOLIN R PER SLIDING SCALE AC AND HS 151- [to] 200 3U, 201-250 5U..."

Review of the Medication Administration Record (MAR) and patient record log/request for treatment plan for August 2009 revealed 10 of 31 opportunities with no documentation of blood glucoses (BG) being obtained as ordered and care planned. Review of the August 2009 MAR and the patient record log/request for treatment plan documented the following:
 a. 8/10/09 at 8:00 PM - BG 223, no SSI was documented as given, correct dose was 5U.
 b. 8/16/09 at 8:00 PM - BG 167, no documentation that SSI was given, correct dose was 3U. The care planned was not followed to administer medications as ordered.

Review of Resident #4's physician's orders dated 9/11/09 documented, "...OBTAIN ACCUCHECKS Q [every] AM AT 6 AM WITH SSI NOVOLIN R ...151-200 = [amount of insulin to be administered] 3U..." Review of the MAR and patient record log/request for treatment plan for

F 282

3. The licensed nursing staff was in serviced regarding following the physicians orders and documentation of medications and accuchecks on 11/10/09 by the DON.
 The licensed nursing staff was in serviced regarding following the plan of care on 11/10/09 by the DON.
 Nurses not inserviced on this date will be inserviced prior to returning to duty . No agency nurses are utilized at this time. Inservice will be conducted upon hire and annually thereafter. Agency nurses will be inserviced prior to working. These inservices will be conducted by the Director of Nursing or the RN supervisor. A tool was developed by the NC,RN on 11/10/09 to audit the documentation of blood glucoses as ordered by the physician and the notification of the physician of blood sugars outside the parameters. This tool will show that the care plan is being followed in relation to administering medication as ordered and doing accuchecks as ordered, and notifying the physician.

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Continued From page 19
 September 2009 revealed 6 of 31 opportunities with no documentation of a BG being obtained as care planned. Review of Resident #4's September 2009 MAR and the patient record log/request for treatment plan documented the following:
 a. 9/25/09 at 6:00 AM - BG 175, no documentation that SSI was given, correct dose was 3U.
 b. 9/26/09 at 6:00 AM - BG 187, no documentation that SSI was given, correct dose was 3U.
 c. 9/27/09 at 6:00 AM - BG 160, no documentation that SSI was given, correct dose was 3U.
 d. 9/30/09 at 6:00 AM - BG 168, no documentation that SSI was given, correct dose was 3U. The care planned was not followed to administer medications as ordered.
 Review of the MAR and patient record log/request for treatment plan for October 2009 revealed 10 of 30 opportunities with no documentation of a BG being obtained. The care planned was not followed for obtaining BG levels.
 2. Medical record review for Resident #14 documented an admission date of 2/26/09 with diagnoses of Mood Disorder, Benign Prostate Hypertrophy, Suicidal Ideation, Diabetic Retinopathy, Gastroesophageal Reflux Disease, Hypertension and Diabetes Mellitus. Review of the physician's admission orders dated 2/27/09 documented "...Accuchecks ac [before meals] & [and] hs [hour of sleep] ... 6AM... 11AM... 4PM... 9PM..." Review of the care plan dated 2/26/09 and updated 6/11/09 and 9/20/09 documented, "...Risk for complications r/t [related to] dx [diagnosis] Diabetes Mellitus... Monitor/record

F 282

4. The Monitoring Accuchecks/MD Notification Audit Tool has been done daily by the Director of Nursing or NC,RN since 11/11/09 and will continue to be done daily by the DON, NC,RN, and the RN supervisor for 3 more weeks and the weekly for 4 weeks and then monthly for 1 month and then quarterly for the next 12 months. Findings will be reported to the QA committee weekly for 4 weeks and then monthly for 1 month and then quarterly for the next 12 months. The QA committee, comprised of the Administrator, the Director of Nursing, the Medical Director, Dietician /food service manager, the Pharmacy Consultant, the Social Services director, the Activity director, the environmental services director, the MDS coordinator, and others as appointed by the administrator, will make any needed changes to the plan.

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F 282	<p>Continued From page 20</p> <p>blood sugar as ordered per MD Monitor for S/S hypo/hyperglycemia as needed Administer meds as ordered per MD..."</p> <p>Review of Resident #14's March 2009 MAR documented "...NOVOLOG ...GIVE 15 UNITS DAILY AT 7am... NOVOLOG ...GIVE 15 UNITS SUBQ [subcutaneous] AT 1130A... NOVOLOG ...GIVE 15 UNITS SUBQ DAILY AT 4PM... LANTUS ...50 UNITS SUBQ DAILY AT HS [hour of sleep]..." There was an entry written in on the March 2009 MAR for "...Accu [check] 6AM..." There was no documentation that the BG was checked at 6:00 AM on 3/1/09 and 3/4/09. The 7:00 AM dose of Novolog was left blank, and not initialed as given for 3/1/09 through 3/4/09. The 11:30 AM Novolog dose was left blank, and not initialed as given for 3/4/09. The 3/5/09 4:00 PM dose was left blank as not given.</p> <p>Review of Resident #14's readmission orders dated 3/6/09 documented "...Continue current medications except changes in Insulin doses... Reduce Lantus to 25 units at 9 pm subcu and start Lantus 10 units in the morning subcu 6A. A total of 35 units Lantus per day instead of 50 units q [every] PM... Novolog 12 units before breakfast, lunch & [and] supper... D/C [discontinue] previous Novolog... Continue to monitor BS 4x/day [four times per day]..."</p> <p>Review of Resident #14's BG flow sheets for 3/7/09 through 3/21/09 documented 60 opportunities for the BG to be checked. There were 3 opportunities with no documentation that the BG had be obtained as ordered. Resident #14's BG ranged from a low of 54 on 3/8/09 at 9:00 PM to a high of 541 on 3/15/09 at 8:00 PM.</p>	F 282		
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F 282	<p>Continued From page 21</p> <p>Review of the nurses note dated 3/11/09 at 7AM, documented "...Resident [#14] found...in floor in room by bed... Assisted out of floor...resident became diaphoretic. BG checked - 56..." A telephone order obtained on 3/11/09 documented "...D5W [Dextrose 5 percent Water] @ 70 cc [cubic centimeter] / [per] hr [hour] until BG over 300 then D/C... Blood glucose Q2 [every two hours] X [times] 24 [hours]... Hold all insulin for now... [change] Lantus to Levimir 20U [units] @ HS & 10 U in am..." The every two hour BG were obtained from 8:30 AM until 10:30 PM. The BG were 81, 160, 342 (Dextrose 5 percent Water (D5W) infusion was stopped), 496, 493, 302, 129, 96. There was no documentation that the Q2 hour BS were obtained after 10:30 PM on 3/11/09.</p> <p>Review of Resident #14's March 2009 MAR and patient record log documented BG as follows:</p> <ul style="list-style-type: none"> a. 3/13/09 at 6:00 AM - BG = no documentation the BG was obtained. b. 3/13/09 at 9:00 PM - BG = 532, Novolog 14U given, no order for this insulin administration. c. 3/14/09 at 3:00 PM - BG = 510, Novolog 14U given, no order for this insulin administration. d. 3/15/09 at 8:00 PM - BG = 541, Novolog 14U given, no order for this insulin administration. <p>The care plan was not followed for administering medications as ordered.</p> <p>Review of Resident #14's blood sugar flow sheet for 3/22/09 through 3/31/09 documented 40 opportunities for the BG to be checked. The BG ranged from 99 on 3/24/09 at 8:00 PM to 481 on 3/26/09 at 9:00 PM. There were 8 times with the wrong doses of insulin being given. The BG with the incorrect SS1 were as follows:</p> <ul style="list-style-type: none"> a. 3/23/09 at 5:00 PM - BG = 326, Insulin given = 12U, correct dose = 10U. 	F 282		
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F 282	<p>Continued From page 22</p> <p>b. 3/23/09 at 9:00 PM - BG = 209, Insulin given = 12U, correct dose = 6U.</p> <p>c. 3/24/09 at 11:00 AM - BG = 162, Insulin given = 12U, correct dose = 4U.</p> <p>d. 3/24/09 at 5:00 PM - BG = 229, Insulin given = 12U, correct dose = 6U.</p> <p>e. 3/25/09 at 9:00 PM - BG = 262, Insulin given = 0U, correct dose = 8U.</p> <p>f. 3/29/09 at 9:00 PM - BG = 466, SSI given = 0U, correct dose = 14U.</p> <p>g. 3/30/09 at 6:00 AM - BG = 259, Insulin given = 0, correct dose = 8U.</p> <p>h. 3/31/09 at 8:00 PM - BG = 423, Insulin given = 14U. There was no order for insulin to be given for this blood sugar level.</p> <p>The care plan was not followed when the correct insulin dose was not administered or when insulin was given with no order.</p> <p>Review of Resident #14's physician orders dated 8/1/09 documented " ...LEVIMIR INSULIN 20u q am ... ACCUCHECK AC AND HS SS [sliding scale] NOVOLOG INSULIN ... 150-200 4U ...201-250 6 U ...251-300 8U ...301-350 10U ...351-400 15 U ... [No physician order for Novolog sliding scale insulin for BG range of 401-450] ...451-14U AND MONITOR Q 4 HRS TIL [until] STABLE ..." There was no physician order for Levimir Insulin 25 U HS that was hand written onto the August 2009 MAR. There was no physician's order for SS Novolog Insulin for a BG range of 401-450. There was no documentation that the physician was notified that there were no orders for SS insulin for a BG range of 401-450 nor was a physician order obtained for SS Insulin for BG levels within the range of 401-450. Review of Resident #14's August 2009 MAR documented 24 doses of Levimir 25 U insulin given at 9:00 PM without an order for Levimir 25</p>	F 282		

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F 282	<p>Continued From page 23</p> <p>U HS. There was one instance of the wrong sliding scale insulin given (Humalog instead of the physician ordered Novolog), on 8/14/09 at 4 PM. The care plan was not followed for administering medications as ordered.</p> <p>Review of Resident #14's August 2009 BG flow sheets documented 124 opportunities for BG to be checked. There were 4 opportunities for BG to be checked with no documentation that a BG was obtained. The BG ranged from a low of 58 on 8/14/09 at 8:00 PM to a high of 517 on 8/20/09 at 11:00 AM. The August 2009 BG flow sheets noted insulin was not administered as ordered as follows:</p> <p>a. 8/2/09 at 8:00 PM - BG = 158, Insulin given = "Levimir given", no documentation of Novolog sliding scale insulin given as ordered, correct dose = 4U.</p> <p>b. 8/4/09 at 4:00 PM - BG = 416, Insulin given = 14U. There was no order for sliding scale insulin to be given for a BG of 401-450. Physician order for 14 U was for a BG of 451 or greater.</p> <p>c. 8/6/09 at 4:00 PM - BG = 404, Insulin given = 15U. There was no order for sliding scale insulin to be given for a BG of 401-450. The physician order for a BG range of 351-400 required a dose of 15 U of Novolog sliding scale insulin.</p> <p>d. 8/7/09 at 8:00 PM - BG = 231, Insulin given = "Levimir [25 U]", no documentation of Novolog sliding scale insulin given as ordered, correct dose = 6U.</p> <p>e. 8/11/09 at 8:30 PM - BG = 231, Insulin given = "Levimir [25U]", no documentation of Novolog sliding scale insulin given as ordered, correct dose = 6U.</p> <p>f. 8/14/09 at 4:00 PM - BG = 507, Insulin given = There was a blank space with no documentation of Novolog sliding scale insulin given as ordered, correct dose = 14U.</p>	F 282		
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F 282	<p>Continued From page 24</p> <p>g. 8/14/09 at 4:00 PM - BG = 448, Insulin given = Humalog 15U. The wrong insulin was administered; there is no physician order for Humalog insulin to be administered. The physician order was for Novolog sliding scale insulin but the physician order did not address the amount of Novolog sliding scale insulin to be given for a BG range of 401-450.</p> <p>h. 8/15/09 at 8:00 PM - BG = 251, Insulin given = "Levimir given [25 U]", no documentation of Novolog sliding scale insulin given as ordered, correct dose = 8U.</p> <p>i. 8/16/09 at 8:00 PM - BG = 348, Insulin given = "Levimir given [25 U]", no documentation of Novolog sliding scale insulin given as ordered, correct dose = 10U.</p> <p>j. 8/18/09 at 8:00 PM - BG = 234, Insulin given = 8U, correct dose = 6U.</p> <p>k. 8/19/09 at 4:00 PM - BG = 424, Insulin given = 15U. There was no order for Novolog sliding scale insulin to be given for BG range of 401-450. The physician order for a BG range of 351-400 required a dose of 15 U of Novolog sliding scale insulin.</p> <p>l. 8/21/09 at 4:00 PM - BG = 410, Insulin given = 15U. There was no order for sliding scale insulin to be given for BG range of 401-450. The physician order for a BG range of 351-400 required a dose of 15 U of Novolog sliding scale insulin.</p> <p>m. 8/24/09 at 6:00 AM - BG = 152, Insulin given = "0 [no Novolog sliding scale insulin given] held pt [patient] "brittle", correct dose = 4U.</p> <p>n. 8/24/09 at 4:00 PM - BG = 445, Insulin given = 15U. There was no order for Novolog sliding scale insulin to be given for BG range of 401-450. The physician order for a BG range of 351-400 required a dose of 15 U of Novolog sliding scale insulin.</p>	F 282		
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F 282	<p>Continued From page 25</p> <p>o. 8/25/09 at 4:00 PM - BG = 247, Insulin given = There was a blank space with no documentation of Novolog sliding scale insulin given as ordered, correct dose = 6U.</p> <p>p. 8/25/09 at 8:00 PM - BG = 151, Insulin given = "0 [0 units]", correct dose = 4U.</p> <p>q. 8/29/09 at 4:00 PM - BG = 224, Insulin given = There was a blank space with no documentation of Novolog sliding scale insulin given as ordered, correct dose = 6U.</p> <p>The care plan was not followed for medication administration when the wrong insulin (Humalog) was administered, wrong insulin doses of Novolog sliding scale insulin were administered, Novolog sliding scale insulin was not administered as ordered when the BG level required administration of insulin and the administration of insulin for a BG of 401-450 without physician orders for this range of BG.</p> <p>Levimir long acting insulin 25 U was documented to be given 5 times by the same Nurse #10, on the evening shift at 8 PM and 8:30 PM, with no physician orders for Levimir 25 U HS. There was no documentation of Novolog sliding scale insulin administered per physician orders for (5 times) 8/2, 8/7, 8/11, 8/15, and 8/16/09.</p> <p>Review of Resident #14's nurses' notes dated 8/14/09 documented "...Accu [check] @ 4PM = 448 SS..." There was no order to give SSI for the BG of 448.</p> <p>A nurses' note dated 9/11/09 at 11:30 PM for Resident #14 documented, "...Found diaphoretic, pale & lethargic. Blood sugar checked c result of 22. Accucheck again -- "too low to be read" ...Ambulance called, report given...9/12/09 3AM... RTF [return to facility] per ambulance c [with] new</p>	F 282		
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F 282	<p>Continued From page 26 MD orders--Skin warm & dry - Color pale..."</p> <p>Review of Resident #14's recertification physician's orders dated 9/2/09 documented, "Levemir 25 Units Subcutaneous Every HS At 9 PM For Diabetes... Levimir Insulin 20 u Q AM... Accuchecks AC and HS SS Novolog Insulin 150-200=4u, 201-250=6u, 251-300=8u, 301-350=10u, 351-400=15u, 451-14u And Monitor Q [every] 4 HRS Til [until] Stable..."</p> <p>Review of a telephone order dated 9/11/09 documented, "...[decrease] Levemir Insulin to 12 units @ hs." Review of a Return to Facility (RTF) orders dated 9/12/09 documented, "...2. Change Novolog Insulin sliding scale subcut [subcutaneous] 150-200=4units, 201-250=6units, 251-300=8units, 301-350=10units, 351-400=12 units, 401 or greater=14 units and monitor Q4 hours til stable and notify MD."</p> <p>A nurses' notes dated 9/11/09 at 11:30 PM documented, "[Resident #14] Found diaphoretic, pale & lethargic. Blood sugar checked c result of 22. Accucheck again--'too low to read'...Ambulance called..." The 9/11/09 nurses' noted documented a low BG of 22. The resident was exhibiting signs and symptoms of hypoglycemia (a low BG).</p> <p>Review of Resident #14's September 2009 MAR documented that Levimir was administered at the wrong dose on 2 occasions for the PM dosage. Review of Resident #14's September 2009 BG flow sheet documented 120 opportunities for the BG to be checked. There were 18 with the wrong doses of insulin given. The BG ranged from a low of 62 on 9/8/09 at 11:00 AM to a high of 467 on 9/23/09 at 4:00 PM. The BG with the incorrect SSI were as follows:</p>	F 282		
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F 282	<p>Continued From page 27</p> <p>a. 9/2/09 at 4:00 PM - BG = 241, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 6U.</p> <p>b. 9/2/09 at 8:00 PM - BG = 208, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 6U.</p> <p>c. 9/7/09 at 6:00 AM - BG = 165, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 4U.</p> <p>d. 9/8/09 at 4:00 PM - BG = 229, Insulin that was documented as given = 4U, correct dose = 6U.</p> <p>e. 9/8/09 at 8:00 PM - BG = no documentation that a BG was obtained.</p> <p>f. 9/12/09 at 6:00 AM - BG = 317, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 10U.</p> <p>g. 9/12/09 at 8:00 PM - BG = 264, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 8U.</p> <p>h. 9/13/09 at 4:00 PM - BG = 289, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 8U.</p> <p>i. 9/14/09 at 4:00 PM - BG = 155, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 4U.</p> <p>j. 9/14/09 at 4:00 PM - BG = 307, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 10U.</p> <p>k. 9/15/09 at 6:00 AM - BG = 230, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 6U.</p> <p>l. 9/16/09 at 8:00 PM - BG = 239, Insulin given = 25U Levimir. The order for Scheduled PM Levimir was for 12u. The documented 25u Levimir given was a wrong dose and the correct dose of SS = 8U Novolog. No SS Insulin was documented as given on the MAR or the BG flow sheet.</p> <p>m. 9/17/09 at 4:00 PM - BG = 269, No SS Insulin was documented as given on the MAR or on the</p>	F 282		
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Continued From page 28
 BG flow sheet, correct dose = 8U.
 n. 9/17/09 at 8:00 PM - BG = 176, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 4U.
 o. 9/18/09 at 6:00 AM - BG = 201, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 6U.
 p. 9/20/09 at 6:00 AM - BG = 215, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 6U.
 q. 9/26/09 at 8:00 PM - BG = 306, Insulin given = 20U Levimir. The order for Scheduled PM Levimir was for 12u. The documented 20u Levimir given was a wrong dose and the correct dose of SS = 10U Novolog. No SS Insulin was documented as given on the MAR or on the BG flow sheet.
 r. 9/27/09 at 9:00 PM - BG = 204, Insulin given = 12U Levimir. The resident should have received 6 units of Novolog but there was no documentation any Novolog was given. The care plan was not followed for administering medications as ordered.

Review of Resident #14's physician's orders dated 10/21/09 documented "...LEVIMIR INSULIN 20U Q AM..." and an order initiated 9/12/09 for "...ACCUCHECKS AC AND HS WITH SLIDING SCALE INSULIN NOVOLOG 0-149= [amount of insulin to be administered] 0 UNITS, 150-200=4 UNITS, 201-250=6 UNITS, 251-300=8 UNITS, 301-350=10 UNITS, 351-400=12 UNITS, 401 OR GREATER=14 UNITS AND MONITOR Q 4 HOURS UNTIL STABLE AND NOTIFY MD..."

Review of Resident #14's October 2009 MAR documented that Levimir 12 units was administered at 8:00 PM from 10/21/09 through 10/31/09 without an order. Review of the October 2009 BG flow sheet documented 124

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F 282	<p>Continued From page 29</p> <p>opportunities for BG to be checked. There were 16 with the wrong doses of insulin given. The BG with the incorrect SSI was as follows:</p> <p>a. 10/2/09 at 11:00 AM - BG = 214, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 6U.</p> <p>b. 10/5/09 at 9:00 PM - BG = 308, Insulin given = 12U Levimir, there was no documentation on the MAR or BG flow sheet of SS insulin given. The correct dose = 10U Novolog.</p> <p>c. 10/6/09 at 6:00 AM - BG = 332, Insulin given = 8U, correct dose = 10U.</p> <p>d. 10/9/09 at 6:00 AM - BG = 150, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 4U.</p> <p>e. 10/10/09 at 6:00 AM - BG = 150, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 4U.</p> <p>f. 10/11/09 at 11:00 AM - BG = 267, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 8U.</p> <p>g. 10/15/09 at 6:00 AM - BG = 251, Insulin given = 6U, correct dose = 8U.</p> <p>h. 10/15/09 at 9:00 PM - BG = 159, Insulin given = 12U Levimir, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 4U.</p> <p>i. 10/16/09 at 11:00 AM - BG = 312, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 10U.</p> <p>j. 10/18/09 at 6:00 AM - BG = 261, Insulin given = 6U, correct dose = 8U.</p> <p>k. 10/20/09 at 4:00 PM - BG = 300, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 8U.</p> <p>l. 10/21/09 at 11:00 AM - BG = 370, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 12U.</p> <p>m. 10/21/09 at 4:00 PM - BG = 260, No amount of</p>	F 282		
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F 282	<p>Continued From page 30 .</p> <p>SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 8U. n. 10/21/09 at 9:00 PM - BG = 178, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 4U. o. 10/25/09 at 9:00 PM - BG = 394, Insulin given = 14U, correct dose = 12U. p. 10/29/09 at 11:00 AM - BG = 215, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 6U. The care plan was not followed for medication administration when wrong insulin and wrong insulin doses were administered.</p> <p>Review of Resident #14's physician's orders dated 11/2/09 documented the same insulin orders as for October 2009. There were 32 opportunities for the BG to be checked from 11/1/09 through 11/9/09. There were three times with the wrong doses of insulin given. The BG with the incorrect SSI given were as follows: a. 11/3/09 at 11:00 AM - BG = 229, No amount of SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 6U. b. 11/6/09 at 6:00 AM - BG = 178, No amount of SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 4U. c. 11/9/09 at 11:00 AM - BG = 230, No amount of SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 6U. The care plan was not followed for medication administration when wrong insulin doses were administered.</p> <p>3. Medical record review for Resident #15 documented an admission date of 7/10/09 with diagnoses of Diabetes, Hypertension, Tobacco Use Disorder and Below Knee Amputation. Review of the care plan dated 7/15/09 and</p>	F 282		

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F 282	<p>Continued From page 31</p> <p>updated 10/27/09 documented, "Monitor/record blood/glucose levels as ordered..." Review of a physician's order dated 8/12/09 and 9/1/09 documented, "...ACCU CHECK AC [before meals] /HS W [WITH] NOVOLIN R SS [SLIDING SCALE] COVERAGE 0-60 = 4oz [ounces] OJ [orange juice] 61-150 = NO COVERAGE, 151-200 = 2U, 201-250 = 4U, 251-300 = 6U, GREATER THAN 300 = 8U..." Review of Resident #15's August 2009 MAR and patient record log documented a BG of 40 on 8/4/09 at 4:30 PM. Review of the August 2009 MAR documented actions taken as "ate dinner with sweets" rechecked BG at 5:30 PM, BG was 116. There was no documentation that the physician was notified of the low BG of 40. Review of the MAR and patient record log/request for treatment plans for August 2009 revealed 8/1/09 through 8/31/09 there was no documentation that bedtime (HS) BG were obtained.</p> <p>Review of the MAR and patient record log/request for treatment plans for 9/1/09 through 9/30/09 revealed there was no documentation that the HS BG had been obtained. Review of Resident #15's September 2009 MAR and patient record log/request for treatment plan documented a BG of 45 on 9/28/09 at 6:30 AM, apple juice given. A rechecked BG of 84 on 9/28/09 at 6:45 AM. There was no documentation that the physician was notified of the low BG of 45.</p> <p>Review of the MAR and patient record log/request for treatment plans for 10/1/09 through 10/31/09 revealed there was no HS BG obtained. The care plan was not followed for obtaining BG levels.</p> <p>5. Medical record review for Resident #16 documented an admission date of 10/23/09 with</p>	F 282		
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F 282	Continued From page 32 diagnoses of Diabetes, Ankle Fracture, Morbid Obesity, Hypertension, Parkinson's Disease, General Anxiety, Depression, Chronic Obstructive Pulmonary Disease and Obstructive Sleep Apnea. Review of the care plan dated 10/23/09 documented, "...Monitor/record blood/glucose levels as ordered per MD..." Review of the physician's orders dated 11/3/09 documented, "Lantus 6 Units SQ [subcutaneous] at HS...Accucheck AC and HS c SS R [regular] insulin 201- 250 =3U, 251-300 =6U, 301 -350 = 9U, 351 - 400 = 12U, > [greater than] 400 = 12U and recheck in 1 hour..." Review of the MAR and patient record log/request for treatment plans for November 2009 documented 1 of 11 opportunities with no documentation of BG being obtained. The facility staff failed to follow the care plan for obtaining BG levels. Review of Resident #16's November 2009 MAR and patient record log/request for treatment plan documented a BG of 49 on 11/8/09 at 6:00 AM, kool-aid given. The care plan was not followed for notifying the physician of the low BG of 49. 6. During an interview in the conference room on 11/11/09 at 8:15 AM, the Minimum Data Set (MDS) nurse verified that the care plans needed to be followed.	F 282		
F 309 SS=E	Refer to F157 and F333. 483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	F309 1. Resident #4 is receiving accuchecks per current physicians order. This is confirmed by the Accucheck/MD notification audit started on 11/10/09 done by the NC.	11-25-09

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F 309	<p>Continued From page 33</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and interview, it was determined the facility failed to follow physician's orders for obtaining accuchecks or ensure an order was written for hospice care for 5 of 18 (Residents #4, 10, 14, 15 and 16) sampled residents.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Review of the facility's "Accucheck/Diabetic Policy and Procedure" policy documented, "It is the policy of this facility to perform Accuchecks... as ordered by the resident's attending physician. Procedure 1. Accucheck will be performed as ordered by the physician..." Medical record review for Resident #4 documented an admission date of 2/26/09 with a readmission date of 10/1/09 with current diagnoses of Diabetes, Aphasia, Hypertension, Convulsions, Stroke with Hemiparesis and Dementia. Review of a physician's order dated 8/27/09 documented obtain accucheck every AM at 6 AM. <p>Review of Resident #4's August 2009 MAR and the patient record log/request for treatment plan revealed there was no accucheck documented as being done on 8/29/09 at 6:00 AM.</p> <p>Review of Resident #4's physician's orders dated 9/11/09 documented, "...OBTAIN ACCUCHECKS Q AM AT 6 AM..."</p> <p>Review of Resident #4's September 2009 MAR</p>	F 309	<p>Resident #10 now has a physician's order to continue hospice care.</p> <p>Resident #14's physician was contacted by the DON on 11/19/09. Resident #14 now has accuchecks done and documented per physician order. This is confirmed by the Accucheck/MD notification audit started on 11/10/09 by the NC</p> <p>Resident #15 now has accuchecks done and documented per physician order. This is confirmed by the Accucheck/MD notification audit started on 11/10/09 by the NC</p> <p>Resident #16 now has accuchecks done and documented per physician order. This is confirmed by the Accucheck/MD notification audit started on 11/10/09 by the NC</p>	
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F 309	<p>Continued From page 34 and the patient record log/request for treatment plan revealed the following:</p> <p>a. 9/7/09 at 6:00 AM - no documentation of an accucheck being done.</p> <p>b. 9/18/09 at 6:00 AM - no documentation of an accucheck being done.</p> <p>Review of the physician's order dated 10/26/09 documented, "...OBTAIN ACCUCHECKS Q AM AT 6 AM..."</p> <p>Review of Resident #4's October 2009 MAR and patient record log/request for treatment plan revealed the following:</p> <p>a. 10/15/09 at 6:00 AM - no documentation of an accucheck being done.</p> <p>b. 10/16/09 at 6:00 AM - no documentation of an accucheck being done.</p> <p>c. 10/26/09 at 6:00 AM - no documentation of an accucheck being done.</p> <p>d. 10/27/09 at 6:00 AM - no documentation of an accucheck being done.</p> <p>e. 10/28/09 at 6:00 AM - no documentation of an accucheck being done.</p> <p>f. 10/29/09 at 6:00 AM - no documentation of an accucheck being done.</p> <p>g. 10/30/09 at 6:00 AM - no documentation of an accucheck being done.</p> <p>3. Medical record review for Resident #10 documented an admission date of 5/20/09 with diagnoses of Alzheimer Disease, Dementia with Lewy Bodies, Cardiovascular Accident and Psychosis Disorder with Delusions. Review of the physician's recertification order dated 11/2/09 did not include an order for hospice care. Review of the Nurses Notes dated 11/7/09 documented hospice care continues.</p>	F 309	<p>2. Other residents with the potential to be affected were identified by a review of residents with orders for accuchecks and residents with orders for hospice care through a record review done by the DON on 11/19/09. Physician's computerized orders for all residents were reconciled with handwritten orders for the past three months by the Director of Nursing, Adm, NC, MDS nurse, and Med Rec Nurse on 11/15/09</p> <p>3. Licensed nursing staff were in serviced on obtaining and documenting accuchecks as ordered and following physicians orders by the DON on 11/19/09. Nurses not in serviced on this date will be in serviced prior to returning to duty. No agency nurses are utilized at this time. In-service will be conducted upon hire and annually thereafter. Agency nurses will be in serviced prior to working. These in-services will be conducted by the Director of Nursing or the RN supervisor.</p>	
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F 309	<p>Continued From page 35</p> <p>During an interview in the conference room on 11/10/09 at 1:50 PM, the Director of Nursing (DON) stated, "The orders are checked by the Medical Records Nurse, she then puts them out at the desk for the night shift nurses to check the orders ... night shift nurses are doing the recap [recapitulation] of the orders..."</p> <p>4. Medical record review for Resident #14 documented an admission date of 2/26/09 with diagnoses of Mood Disorder, Benign Prostate Hypertrophy, Suicidal Ideation, Diabetic Retinopathy, Gastroesophageal Reflux Disease, Hypertension and Diabetes Mellitus. A telephone order dated 2/26/09 documented "... Fax BG [blood glucose] to office on 3-5-09..." Review of the physician's admission orders dated 2/27/09 documented "...Accuchecks ac [before meals] & [and] hs [bedtime] ...6AM...11AM...4PM...9PM..."</p> <p>Review of Resident #14's March 2009 Medication Administration Record (MAR) had an entry written to obtain "...Accu [check] 6AM..." There was no documentation that the BG was checked at 6:00 AM on 3/1/09 and 3/4/09. The BG results for 6:00 AM were documented as follows: 3/2/09 was (=) 148, 3/3/09 BG = 67 and 3/5/09 BG = 146. There was no documentation that the BG results were faxed to the attending physician as ordered.</p> <p>Review of Resident #14's BG flow sheets for 3/7/09 through 3/21/09 documented 60 opportunities for the BG to be checked. There were 3 opportunities that there was no documentation that the BG were obtained.</p> <p>Review of the nurses note dated 3/1 1/09 at 7AM, documented "...Resident [#14] found...in floor in room by bed... Assisted out of floor...resident</p>	F 309	<p>The Director of Nursing and the RN supervisors will perform monthly physician orders reconciliation.</p> <p>An audit tool, Accucheck/MD notification was created by NC or 11/10/09.</p> <p>4. The Director of Nursing or RN supervisor will complete the Accucheck/MD notification Audit tool 5 days a week for 4 weeks then monthly for 1 month and then quarterly for the next 12 months .</p> <p>The Medical Records nurse will audit 2 medical records weekly ongoing to ensure correct procedure for physicians orders. The results of these audits will be brought the QA committee</p> <p>weekly for 4 weeks then monthly for 1 month and then quarterly for the next 12 months.</p> <p>The QA committee, comprised of: the Administrator, the Director of Nursing, the Medical Director, Dietician /food service manager, the Pharmacy Consultant, the Social Services director, the Activity director, the</p>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER BAILEY PARK CLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 MITCHELL STREET HUMBOLDT, TN 38343
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Continued From page 36
became diaphoretic. BG checked - 56..." A telephone order obtained on 3/11/09 documented "...D5W [Dextrose 5 percent Water] @ 70 cc [cubic centimeter] / [per] hr [hour] until BG over 300 then D/C... Blood glucose Q2 [every two hours] X [times] 24 [hours]..." The every two hour BG were obtained from 8:30 AM until 10:30 PM. The BG were 81, 160, 342 (D5W infusion was stopped), 496, 493, 302, 129, 96. There was no documentation that the Q2 hour BG were obtained after 10:30 PM on 3/11/09.

Review of Resident #14's March 2009 MAR revealed no documentation of the BG being obtained on 3/13/09 at 6:00 AM.

Review of Resident #14's physician's orders dated 8/1/09 documented an order initiated 2/27/09 for "...ACCUCHECK AC AND HS..." Review of the August 2009 BG flow sheets documented 124 opportunities for BG to be checked. There were 4 opportunities with no documentation that BG were obtained.

5. Medical record review for Resident #15 documented an admission date of 7/10/09 with diagnoses of Diabetes, Hypertension, Tobacco Use Disorder and Below Knee Amputation. Review of Resident #15's physician's order dated 8/12/09, 9/1/09 and 10/21/09 documented, "ACCU CHECK AC/HS... [results] 0- [to] 60 = [give] 4oz [ounces] OJ [orange juice]..."

Review of Resident #15's August 2009 MAR and patient record log/request for treatment plan documented the following:
a. 8/29/09 at 6:30 AM - no documentation of an accucheck being done.
b. 8/30/09 at 4:30 PM - no documentation of an

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environmental services director, the MDS coordinator, and others as appointed by the administrator, will make any needed changes to the plan .

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F 309	<p>Continued From page 37 accucheck being done. c. 8/1/09 through 8/31/09 there was no documentation that the HS accuchecks were done.</p> <p>Review of Resident #15's September 2009 MAR and patient record log/request for treatment plan documented the following: a. 9/2/09 at 11:00 AM - no documentation of an accucheck being done. b. 9/18/09 at 4:30 PM - no documentation of an accucheck being done. c. 9/24/09 at 6:30 AM - no documentation of an accucheck being done. d. 9/1/09 through 9/30/09 (except for 9/6/09) there was no documentation that the HS accuchecks had been done.</p> <p>Review of Resident #15's October 2009 MAR and patient record log/request for treatment plan documented the following: a. 10/7/09 at 4:30 PM - no documentation of an accucheck being done. b. 10/8/09 at 6:30 AM - no documentation of an accucheck being done. c. 10/18/09 at 4:30 AM - no documentation of an accucheck being done.</p> <p>5. Medical record review for Resident #16 documented an admission date of 10/23/09 with diagnoses of Diabetes, Ankle Fracture, Morbid Obesity, Hypertension, Parkinson's Disease, General Anxiety, Depression, Chronic Obstructive Pulmonary Disease and Obstructive Sleep Apnea. Review of the physician's order dated 10/26/09 and 11/3/09 documented, "...Accuchecks AC and HS..." Review of the October 2009 MAR and patient record log/request for treatment plan revealed there was no</p>	F 309		

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F 309	Continued From page 38 documentation that a BG was obtained on 10/26/09 at 11:00 AM and 4:00 PM. Review of the November 2009 MAR and patient record log/request for treatment plan revealed there was no documentation that a BG was obtained 11/6/09 at 8:00 PM.	F 309		
F 314 SS=D	<p>483.25(c) PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and observations, it was determined the facility failed to ensure a dressing change was performed under aseptic techniques and failed to follow physician's orders for cleaning the pressure ulcer for 1 of 1 (Resident #3) sampled residents observed for dressing change.</p> <p>The findings included:</p> <p>Review of the facility's "DRESSING CHANGE (CLEAN)" policy documented, "...PURPOSE 1. To protect wound. 2. To prevent infection and spread of infection... INFECTION CONTROL 1. Observe universal precautions... EQUIPMENT ...2. Prescribed cleaning solution(s)... Procedure... 7. Cleanse wound with prescribed solution if ordered..."</p>	F 314	<p>1. Resident #3 is now receiving pressure ulcer dressing change according to aseptic technique and according to physician's orders. This is confirmed by direct observation of dressing change by the DON on 11/14/09. Nurse #9 will not perform wound care until skill competency for dressing change completed.</p> <p>2. Other residents having the potential to be affected were identified by body audits done by the charge nurses according to schedule. Inservices on wound care and dressing changes were started for the nurses on 11/14/09</p> <p>3. RN nursing staff were in serviced on wound care including staging and measurement by the DON on 11/14/09. Other nurses were in serviced on 11/19/09 by the DON regarding wound care and dressing changes.</p>	11-25-09

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F 314	<p>Continued From page 39</p> <p>Medical record review for Resident #3 documented an admission date of 8/31/09 with diagnoses of Acute Kidney Failure, Colostomy, Gastrointestinal Stromal Tumor with Metastasis to the Liver, Pressure Ulcers on the right trochanter, left trochanter, sacrum and right foot, Left Above Knee Amputation and Sepsis. Review of a physician's telephone order dated 11/9/09 documented, "All ulcers to be cleaned c [with] wound cleaner and wet to dry dressings c sterile water cont [continue] soaking foot in soap and water."</p> <p>Observations in Resident #3's room on 11/9/09 at 3:30 PM, revealed Nurse #9 put supplies on the overbed table without a barrier. With gloved hands the nurse cut away the old dressing from Resident #3's right foot pressure ulcer then placed the scissors on the bedspread. After Nurse #9 washed Resident #3's right foot pressure ulcer (stage IV) with soap and water she took a 10 cubic centimeter (cc) syringe of Normal Saline (NS) with a 4 by (x) 4 and wiped across the pressure ulcer wound one time, then took another 4x4 and NS and wiped downward two times. Nurse #9 removed her gloves, put on new gloves, then placed new 4x4's over the pressure ulcer and then applied NS and placed an abdominal (ABD) dressing over the 4x4's and secured with paper tape. After charting the assessment of Resident #3's right foot pressure ulcer, Nurse #9 obtained new supplies from the medication cart that included Kerlix, syringes of NS, gloves and ABD dressing. Nurse #9 placed these items on the overbed table without a barrier. Nurse #9 then obtained paper towels outside of Resident #3's room because there were no more paper towels in the resident's bathroom. Nurse #9 placed the</p>	F 314	<p>A skill competency for aseptic dressing change was started on 11/21/09 for licensed nurses. No nurse will be allowed to perform pressure ulcer dressing changes until the skill competency is completed.</p> <p>A skill competency for dressing changes for licensed nursing staff will be conducted upon hire and then annually thereafter. Skill competency will be on the General Orientation Checklist for nurses.</p> <p>4. The Administrator will review the General Orientation checklist for new nurses ongoing. The Director of Nursing will observe a nurse performing pressure ulcer dressing change weekly for 2 weeks and then monthly for 2 months and then quarterly for the next 12 months. (Start Date 11/14/09) The results of this observation will be reported to the QA committee weekly for 2 weeks, monthly for 2 months, and then quarterly for the next 12 months. The QA committee, comprised of the Administrator, the Director of</p>	
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F 314	Continued From page 40 paper towels on the back of the commode and proceeded to wash her hands, then wiped her hands with the paper towels. Nurse #9 then put on her gloves and took the Kerlix and secured the dressings on Resident #3's right foot pressure ulcer. With the same gloved hands, Nurse #9 removed the old dressing from Resident #3's right Trochanter pressure ulcer (stage IV). After cleaning the pressure ulcer with NS and applying a dressing, Nurse #9 washed her hands, applied new gloves and removed the dressing from Resident #3's sacrum pressure ulcer. The sacrum pressure ulcer was cleansed with NS then a new dressing was applied. Nurse #9 did not follow infection control practices nor did she cleanse the pressure ulcer with a wound cleanser as ordered.	F 314	Nursing, the Medical Director, Dietician /food service manager, the Pharmacy Consultant, the Social Services director, the Activity director, the environmental services director, the MDS coordinator, and others as appointed by the administrator, will make any needed changes to the plan. will make any needed changes to the plan.	
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure the environment was free from accident hazards when chemicals were stored unlocked in a storage room on 1 of 4 (200 hall storage room) halls. The findings included:	F 323	1. The storage room door was closed and secured upon discovery by Nurse #6 on 11/10/09. 2. A tour of the facility was made by the Administrator and Maintenance Director to identify other storage areas that were not secured and any needed action taken. No residents were affected. 3. Nursing, Dietary, Housekeeping, Maintenance, Activity, SS, Administrative staff was in serviced by the Administrator regarding securing areas that contain items that could pose a hazard on 11/18/09.	11-25-09

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F 323	<p>Continued From page 41</p> <p>Review of the facility's "Storage Areas" policy documented, "It is the policy of this facility that storage areas be maintained in a clean and safe manner...Cleaning supplies...shall be stored as instructed on the labels of such products."</p> <p>Observations in the 200 hallway storage room on 11/10/09 at 5:10 AM, revealed the door to the room was propped open. The storage room contained the following chemicals:</p> <ul style="list-style-type: none"> a. Nineteen (19) boxes - Enema Mineral Oil. b. Four (4) Penner Patient Care- whirlpool disinfectant- external use only. c. Four (4) bottles- Allclenz- wound cleanser. d. Fourteen (14) boxes - alcohol preps. e. Four (4) boxes - denture cleanser. f. Eight (8) bottles - cucumber melon conditioner, shampoo and body wash- external use only. g. Three (3) bottles - Mositurizing body lotion - external use only. h. Fifteen (15) bottles - no rinse periwash - External use only. <p>The facility did not have residents that exhibited wandering behaviors.</p> <p>During an interview in room 206B on 11/10/09 at 6:18 AM, Nurse #6 stated, "Well I know we got that one [deficiency] ... I left that door [storage room door] open ...I did it ... I went and left it open..."</p>	F 323	<p>In-service will be done upon hire and annually thereafter.</p> <p>A Hazard Audit was created by the NC on 11/19/09. The tool shows observation of storage areas being secured.</p> <p>4. Rounds will be made daily for 2 weeks then monthly for 1 month for 3 months then quarterly for the next 12 months by the Administrator and documented on the Hazard Audit to ensure storage areas are properly secured. Findings will be reported to the monthly QA committee weekly for 2 weeks, then monthly for 3 months, then quarterly for the next 12 months. The QA committee, comprised of the Administrator, the Director of Nursing, the Medical Director, Dietician /food service manager, the Pharmacy Consultant, the Social Services director, the Activity director, the environmental services director, the MDS coordinator, and others as appointed by the administrator, will make any needed changes to the plan .</p>	
F 332 SS=E	<p>483.25(m)(1) MEDICATION ERRORS</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 332		11-25-09

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F 332	<p>Continued From page 42</p> <p>by: Based on policy review, review of the "MED-PASS" provided by the American Society of Consultant Pharmacists", medical record review, observation and interviews, it was determined the facility failed to ensure the medication error rate was less than five percent (%) for sampled Residents #11, 14, 15 and 18 and Random Residents (RR) #1, 3, 4 and 5. Five (5) of 7 nurses (Nurses #1, 3, 4, 5 and 7) made 11 errors out of 43 opportunities for error which resulted in a medication error rate of 25.58%.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Medical record review for Resident #11 documented an admission date of 2/1/09 with diagnoses of Difficulty Walking, History of Falls, Incontinence, Coronary Artery Disease, Hypertension, Gastric Esophageal Reflux Disease, Peptic Ulcer Disease and Alzheimer's Disease. <p>Observations in Resident #11's room on 11/9/09 at 8:55 AM, revealed Nurse #1 administered an Enteric Coated Aspirin 81 milligrams (mg) and 2 Isosorbide 30 mg tablets.</p> <p>Review of Resident #11's current recertification orders dated 11/2/09 did not include an order for Aspirin or Isosorbide. The administration of Aspirin and Isosorbide without a physician's order resulted in medication errors #1 and #2.</p> <ol style="list-style-type: none"> 2. Review of the "MED-PASS" provided by the American Society of Consultant Pharmacists for typical dosing administration related to meals documented "...Novolog... [administer] 5- [to] 10 minutes before meals..." 	F 332	<p>F 332</p> <ol style="list-style-type: none"> 1. Resident #11's physician was notified on 11/23/09 by the NC. Nurse #1 has been re-educated taken regarding medication administration by the DON on 11/19/09. Resident#11 is now receiving medication per physician's orders. This was validated by the physician order reconciliation by the DON, NC, MDS nurse, and Medical Records Nurse on 11/14 and 11/15/09. Resident #11 sustained no ill effects <p>Resident #14 is now receiving insulin within the appropriate time frame regarding meals. This was validated by the physician order reconciliation by the DON, NC, MDS nurse, and Medical Records Nurse on 11/14 and 11/15/09.</p> <p>Nurse #4 was re-educated regarding the appropriate time frame for insulin administration in relation to meals by the DON on 11/10/09</p>	
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F 332	<p>Continued From page 43</p> <p>Medical record review for Resident #14 documented an admission date of 2/26/09 with diagnoses of Diabetes, Mood Disorder, Benign Prostate Hypertension, Suicidal Ideation, Diabetes Retinopathy, Abnormality of Gait, Gastric Esophageal Reflux Disorder and Hypertension. Review of the physician's orders dated 11/2/09 documented "...SLIDING SCALE INSULIN NOVOLG... 301-350 =10 UNITS..."</p> <p>Observations during medication administration in Resident #14's room on 11/9/09 at 3:50 PM, revealed Nurse #4 obtained a blood glucose (BG) of 332. Nurse #4 administered 10 units of Novolog insulin to Resident #14 at 4:14 PM. Resident #14 had not received his dinner meal at 5:15 PM, one hour after the fast acting insulin had been given. The administration of Novolog more than 15 minutes before Resident #14 was served a meal resulted in medication error #3.</p> <p>During an interview in the conference room on 11/11/09 at 8:35 AM, the Consultant Pharmacist was asked how long he had been consulting with this facility, how often did he come to the facility and what was he responsible for. The Consultant Pharmacist (CP) stated, "I have been coming here pretty close to a year... I am here once a month... I do general medication reviews..." The surveyor asked the CP if he had done any inservices with the nursing staff. The CP stated, "I have not done any recently due to the turn over [with staff]..." The surveyor asked the CP what charts did he review, what did he look at and how often. The CP stated, "Monthly...I look at every chart in the building...chart reviews, I look at allergies, labs and anything to do with medications..." The CP was asked if he had found</p>	F 332	<p>Resident #15 is now receiving medication within the appropriate time frame. This was validated by the physician order reconciliation by the DON, NC, MDS nurse, and Medical Records Nurse on 11/14 and 11/15/09. Nurse #5 was re-educated regarding medication administration timing on 11/19/09 by the DON.</p> <p>Resident #18 is now receiving medication within the appropriate time frame. This was validated by the physician order reconciliation by the DON, NC, MDS nurse, and Medical Records Nurse on 11/14 and 11/15/09. Nurse #5 was re-educated regarding medication administration timing on 11/19/09 by the DON.</p> <p>RR #1 is now receiving Coumadin within the appropriate time frame. This was validated by the physician order reconciliation by the DON, NC, MDS nurse, and Medical Records Nurse on 11/14 and 11/15/09. Nurse #5 was re-educated regarding medication administration on 11/22/09 by the DON.</p>	
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F 332	Continued From page 44 any problems with insulins. The CP stated, "No, I have not... Me and [named the DON] did discuss the timing of insulins..." The CP was asked if he had found in his review any holes/blanks in the MAR. The CP stated, "One hole is too many... I just don't know how to enforce making the nurses scared to leave holes..." The CP was asked if he reviewed the resident's orders and recertification orders. The CP stated, "I do not review every single order... No...There are some [orders] that do not get documented accurately." The CP was asked if he was aware of any serious problems with the recertification orders. The CP stated, "Well, they have a serious problem with staffing...Every month it is different nurses..." The CP was asked if he felt there was a problem at this facility. The CP stated, "Absolutely... Staffing has been a huge issue..." 3. Review of the facility's "MEDICATION ADMINISTRATION-GENERAL GUIDELINES" policy documented, "Procedures... 10) Medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered based on mealtimes..." Medical record review for Resident #15 documented an admission date of 7/10/09 with diagnoses of Diabetes and Hypertension. Review of the physician orders dated 11/2/09 documented, "Metformin HCL 500mg Tab [tablet] (1) po BID [two times a day] for DM [Diabetes Mellitus] ...8AM and 4PM..." Observations in Resident #15's room on 11/10/09 at 5:25 AM, revealed Nurse #5 administered 500 mg of Metformin to Resident #15. The administration of the Metformin two hours and 30	F 332	RR#3 is now receiving the correct dose of Megace. This was validated by the physician order reconciliation by the DON, NC, MDS nurse, and Medical Records Nurse on 11/14 and 11/15/09. Nurse #5 was re-educated regarding liquid medication dosing on 11/22/09. RR #4 is now receiving medication within the appropriate time frame. This was validated by the physician order reconciliation by the DON, NC, MDS nurse, and Medical Records Nurse on 11/14 and 11/15/09. Nurse #5 was re-educated regarding medication administration timing on 11/19/09 by the DON. RR #5 has been discharged. 2. Other residents with the potential to be affected were identified through a medication pass observation with each nurse conducted by the DON and NC started on 11/14/09 through 11/22/09.	

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F 332	<p>Continued From page 45</p> <p>minutes before the ordered time resulted in medication error #4.</p> <p>4. Medical record review for Resident #18 documented an admission date of 7/10/09 with diagnoses of Hyperlipidemia, Incontinence, Osteoarthritis, Disorders of the Thyroid, Coronary Artery Disease and Dementia. A physician's order dated 11/2/09 documented "Glucophage [Metformin an oral hyperglycemic] 500 mg Tab (1) po BID...8AM and 4 PM."</p> <p>Observations in Resident #18's room on 11/10/09 at 5:10 AM, revealed Nurse #5 administered a 500 mg tablet of Metformin to Resident #18. The administration of the Metformin two hours and fifty minutes before the ordered time resulted in medication error #5.</p> <p>5. Medical record review for RR #1 documented an admission date of 1/12/09 with diagnoses of Dislocated Shoulder, Joint Pain, Muscle Weakness, Recurrent Depression. A physician's order dated 11/2/09 documented "Coumadin 3 mg Tablet 1 po Q [every] day at 5 PM."</p> <p>Observations in RR #1's room on 11/9/09 at 3:50 PM, revealed Nurse #3 administered a 3 mg tablet of Coumadin to RR #1. The administration of the coumadin 1 hour and 10 minutes before the ordered time resulted in medication error #6.</p> <p>6. Medical record review for RR #3 documented an admission date of 10/15/09 with diagnoses of Subdural Hemorrhage, Gastrostomy, Aphasia, Dysphagia and Muscle Disuse Atrophy. A physician's order dated 11/4/09 documented, "Megace 40 MG [milligrams / [per] ML [milliliter] Oral Susp [suspension] 80 MG PO [by mouth]</p>	F 332	<p>3. Licensed nursing staff were in serviced regarding medication administration by the Director of Nursing on 11/19/09. A medication pass was done with each nurse by the Pharmacy Consultant and the Director of Nursing and NC starting on 11/14/09 through 11/22/09. No nurse was allowed to pass medication until the medication pass was completed. One to one education was provided as needed during the med pass. A medication pass competency will be completed with nurses upon hire and then annually.</p> <p>4. The Director of Nursing will observe one med pass per week for 4 weeks and then quarterly. The Pharmacy Consultant will conduct a med pass with at least 2 nurses on the monthly visit. The results of these observations will be reported to the QA committee weekly for 4 weeks and then monthly ongoing. The QA committee, comprised of the Administrator, the Director of</p>	
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F 332	<p>Continued From page 46 BID For Appetite."</p> <p>Observations at the medication cart in front of RR #3's room on 11/10/09 at 5:17 AM, revealed Nurse #5 poured up 2.5 ml of Megestrol. The correct megace dose should have been 2 ml not 2.5 ml. This resulted in medication error #7.</p> <p>During an interview at the medication cart in front of RR #3's room on 11/10/09 at 5:17 AM, Nurse #5 stated, "...it's [the amount of Megestrol poured up] right beneath the 2.5 ml."</p> <p>7. Medical record review for RR #4 documented an admission date of 9/14/09 with diagnoses of Morbid Obesity, Diabetes, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease and Muscle weakness. A physician's order dated 11/2/09 documented, "Metformin HCL 1,000 MG Tablet 1 PO BID...8AM and 4PM..."</p> <p>Observations in RR #4's room on 11/10/09 at 5:31 AM, revealed Nurse #5 administered Metformin 1,000 MG to RR #4. The administration of the Metformin two hours and 29 minutes before the ordered time resulted in medication error #8.</p> <p>8. Medical record review for RR #5 documented an admission date of 12/29/09 with diagnoses of Joint Pain, Low Vision, Depressive, Alzheimer's, Vascular Dementia, Incontinence and Osteoarthritis. A physician's order dated 11/2/09 documented, "...Multivitamin TAB [tablet] (1) po QD..." A telephone physician's order dated 11/8/09 documented, "Tesslon Perle 100 MG capsule 3x's [times] a day for 7 days for cough."</p> <p>Observations in RR #5's room on 11/10/09 at</p>	F 332	<p>Nursing, the Medical Director, Dietician /food service manager, the Pharmacy Consultant, the Social Services director, the Activity director, the environmental services director, the MDS coordinator, and others as appointed by the administrator, will make any needed changes to the plan .</p>	

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F 332	Continued From page 47 8:20 AM, revealed Nurse #7 administered Nasocort nose spray with one spray in each nostril of RR #5. There was no physician's order for the Nasocort nose spray. The administration of the Nasocort nose spray without a physician's order resulted in medication error #9. Nurse #7 did not administer a Multivitamin or Tesslon Perle to RR #5. The failure to administer the Multivitamin and Tesslon Perle resulted in medication error #10 and #11. 9. During an interview in the conference room with the Director of Nurses (DON) on 11/10/09 at 2:00 PM, the DON was informed of the medication errors and the problem with the recertification orders. The DON stated, "...Night shift should be recapping [verifying that the recertification orders are complete and correct] ...I have not followed through [with the recertification orders] ...One of the nurses was handling that..." The DON was also asked when she would expect insulins to be given in relation to meals. The DON stated, "...should be given 30 minutes before meals unless it's that special insulin (Novolog and Humalog) ...timing is critical..."	F 332			
F 333 SS=J	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on policy review, review of "MED-PASS" provided by the American Society of Consultant Pharmacists, medical record review, observation and interview, it was determined the facility failed to ensure that residents were free of significant	F 333	1. Residents #4 and #14 are now having their insulin administered within the proper time frame before meals, correct amount, the correct insulin ordered, and as per current physician orders. Physicians for resident #4 and #14 were contacted for clarification orders for correct timing, correct insulin, and correct amount on 11/10 and 11/11/09.	11-10-09	

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F 333	Continued From page 48 medication errors. The nursing staff failed to administer insulin within the proper time frame before meals, administer the correct amount of insulin according to the sliding scale and/or failed to obtain orders for insulin administration for 2 of 8 (Residents #4 and 14) sampled residents the facility had identified and documented as being insulin dependent. The insulin dependent diabetics have the high likelihood of having hypoglycemia and hyperglycemia episodes by receiving the wrong insulin or the wrong insulin doses. A conference was held in the conference room on 11/10/09 at 4:45 PM, at which time the Administrator and Director of Nursing (DON) were informed of the findings that placed the diabetic residents in immediate jeopardy (IJ). The IJ effective date is 11/10/09, and is ongoing until the IJ is removed. The findings included: 1. Review of the facility's "Diabetic Therapeutic Protocol" policy documented. "The physician must approve the use of the Diabetic Therapeutic Protocol for each of his/her resident's use and write a corresponding order in the medical record. Nurses will be informed of this protocol upon hire and regularly thereafter. Hypoglycemia Protocol if the resident is asymptomatic, alert and the fingerstick blood glucose [BG] is less than 50 (or as indicated by the physician): 1. Give a form of carbohydrate that contains glucose. Orange juice with 2 teaspoons of sugar is acceptable. If the resident is unable to swallow due to other medical conditions, give Glucagon 1 mg. [milligram] IM [Intramuscular] now. 2. Recheck the finger stick blood glucose in 15 minutes. 3. If the finger stick blood glucose remains less than 50 and the resident remains asymptomatic, repeat the	F 333	The residents were reassessed and physicians notified by the DON and the NC,RN on 11/10/09 and 11/11/09 2. Other residents with the diagnosis of diabetes have the potential to be affected and the diagnosis was used to identify which resident. The residents identified by the DON and NC,RN had physician orders clarified for insulin administration times and amounts, ranges of insulin, and correct insulin on 11/10/09 and 11/11/09. 3. Nurses were inserviced on 11/10/09 by the Director of Nursing regarding time frames for insulin administration in relation to meals, administering the correct amount and type of insulin, physicians orders and documenting insulin administration. 100 % of nurses were inserviced on the Diabetic Therapeutic Protocol on	

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F 333	Continued From page 49 treatment. 4. Notify the physician. The physician is notified even if resident improves. 5. If the finger stick blood glucose returns to normal, have the resident eat a meal or snack containing a form of protein. (i.e. [such as] a peanut butter or cheese sandwich, milk, cheese and crackers.) If the resident is non responsive and the finger stick glucose is less than 50 (or as indicated by the physician): 1. Give Glucagon 1mg IM now. 2. Notify the physician and prepare for hospital transport. 3. Recheck the finger stick blood glucose in 10 minutes. 4. If the resident remains unresponsive and the finger stick blood glucose is less than 50, give Glucagon 1mg IM now and call for emergency transport to the hospital. 5. Notify the physician and responsible party. Hyperglycemia Protocol If the resident is alert, asymptomatic, and finger stick blood glucose is greater than 450 (or as indicated by the physician): 1. If sliding scale insulin is ordered, give the ordered dose. 2. Recheck the finger stick blood glucose in 10 min. [minutes] If no improvement in the finger stick glucose, notify the physician. 3. If no sliding scale insulin is ordered, notify the physician." Review of the facility's "Accucheck/Diabetic Policy and Procedure" policy documented, "It is the policy of this facility to perform Accuchecks and administer insulin as ordered by the resident's attending physician. Procedure 1. Accucheck will be performed as ordered by the physician. 2. The physician will be notified of Accucheck results not within parameters set by the physicians. 3. Insulin will be administered as ordered by physician, this includes scheduled insulin administration as well as ordered sliding scale insulin. 4. Diabetic Therapeutic Protocol will be implemented for blood glucose less than 50 or	F 333	11/10/09 No agency nurses are utilized at this time. Inservice will be conducted upon hire and annually thereafter. Agency nurses will be inserviced prior to working. These inservices will be conducted by the Director of Nursing or the RN supervisor. An insulin administration skill check off was done for each nurse started on 11/12 and completed on 11/17/09. The skill check included a visual return demonstration. No nurses were allowed to administer insulin until the skill check off was completed. Current physicians orders were obtained on 11/10/09 11/11/09. The insulin administration times were changed on the MAR to reflect proper time frame before meals according to the type of insulin on 11/10/09 and 11/11/09 A medication pass skill check off with each nurse was started on 11/11 and 11/12/09 and continues until all nurses have completed prior to giving medication.	

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F 333	<p>Continued From page 50 greater than 450 unless otherwise ordered by the physician."</p> <p>Review of the facility's "MEDICATION ADMINISTRATION-GENERAL GUIDELINES" policy documented, "Procedures...10) Medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered based on mealtimes..."</p> <p>2. Medical record review for Resident #14 documented an admission date of 2/26/09 with diagnoses of Mood Disorder, Benign Prostate Hypertrophy, Suicidal Ideation, Diabetic Retinopathy, Gastroesophageal Reflux Disease, Hypertension and Diabetes Mellitus. Admission orders signed by a Registered Nurse (RN) on 2/26/09 and signed and dated by the physician on 2/27/09 documented " ...Accuchecks ac [before meals] and hs [bedtime] ...Novolog 18 u [units] sq [subcutaneous] 9 am ...DC ' d [discontinued] See New Order ... Novolog 15 u sq 11 30 A [11:30 AM] ... Novolog 15 u sq 4 pm ... Lantus 80 u sq hs ...dc ' d See New Order ..." A Physician's telephone order dated 2/26/09 at 6:30 PM signed by Nurse #10 and signed by the physician on 3/11/09 documented " ...Give Novolog 15 u @ [at] 700am [7:00 AM] ... Give Lantus 50 u @ hs [hour of sleep] ...Fax BG to office on 3-5-09 ... " Resident #14's hospital transfer "Physician Orders" signed and dated 3/6/09 documented " ...Continue current medications except changes in Insulin doses ... Reduce Lantus to 25 units at 9 pm subcu [subcutaneous] and start Lantus 10 units in Tue [Tuesday] morning subcu 6 A [6:00 AM] ... A total of 35 units Lantus per day instead of 50 units q [every] Pm ...Novolog 12 units before breakfast, lunch & [and] supper ...D/C</p>	F 333	<p>An inservice was done by the Medical Director on 11/19/09 for the nurses regarding insulin onset, peak and duration and the effects of hypo/hyper glycemia.</p> <p>The Medical Records nurse will take the copies of new orders and verify correct transcription by comparing the orders to the administration records 5 times a week ongoing.</p> <p>Orders for sliding scale insulin have been formatted on the MAR in sequence from lowest to highest to make any gaps easily visible to the administering nurse.</p> <p>The consultant pharmacist will ensure that orders and MARs are reconciled through the monthly pharmacy review process. The accuracy of the reconciliation is verified by the pharmacist's signature on the computerized orders.</p>	

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F 333	<p>Continued From page 51</p> <p>[discontinue] previous Novolog ... Continue to monitor BS [Blood Sugar] 4 X [times] / [per] day ... For hypoglycemia - give Orange juice & 2 packs of Sugar and if unresponsive give Glucagon 1 mg IM [intramuscular] PRN [as needed] for hypoglycemia..."</p> <p>A Physician's telephone order dated 3/21/09 documented " ...NO [New Order] for Novolog sliding scale 150- [to] 200 4U, 201-250 6U, 251-300 8U, 301-350 10U, 351-400 12U, 450 & ^[above] 14U & above 450 Monitor q [every] 4 [hours] ..." There is no documented sliding scale insulin order for a BG for 401-149. The nurses did not notify the physician to obtain orders for a SSI done for a BG from 401-449 as per the facility's diabetic therapeutic protocol. The facility's protocol was also for the MD to be notified of blood glucoses below 50 and above 450. There was no physician order written that was different from this parameter.</p> <p>Review of Resident #14's March 2009 Medication Administration Record (MAR) documented "...NOVOLOG ...GIVE 15 UNITS DAILY AT 7am... NOVOLOG ...GIVE 15 UNITS SUBQ [subcutaneous] AT 1130A... NOVOLOG ...GIVE 15 UNITS SUBQ DAILY AT 4PM... LANTUS ...50 UNITS SUBQ DAILY AT HS..." Documentation of "ACCUCHECK AC AND HS" listed the times of "6AM ...11AM ...4PM ...9PM..."</p> <p>There was a separate hand written entry on the March 2009 MAR for "...Accu [check] 6AM..." There was no documentation on the March MAR that the BG was checked at 6:00 AM on 3/1/09 and 3/4/09. (The BG flow sheet documented the 3/1/09 BG was 212 but had no documentation for BG on 3/4/09 at 6 AM.) There was a discrepancy</p>	F 333	<p>Mealtimes for the facility are 7:30 am, 11:30am, and 5pm. Rapid acting insulins: Novalog was scheduled 15 minutes prior to meals. Novolin R was scheduled 30 minutes prior to meals.</p> <p>4. An audit tool, Med Pass/Shift Change Daily Audit developed by the DON on 11/12/09, is being utilized each shift to ensure completeness of the med pass. The audit tool will be done by on duty nurses and involves reviewing the MAR for completeness. It is done between every shift. This will be done daily ongoing. The Director of Nursing or Nurse Consultant will review the audits daily for completeness for 2 weeks then weekly for 2 weeks then monthly for the next 12 months (Start date 11/13/09). The Director of Nursing or the RN supervisor will verify the accuracy of one audit a week for 2 weeks, the one per month for 2 months, and then quarterly for the next 12 months (Start date 11/13/09)</p>	

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F 333	<p>Continued From page 52 between the MAR and the BG flow sheet.</p> <p>On the MAR the BG results for 6:00 AM were documented as follows: 3/2/09 was (=) 148, 3/3/09 BG = 67, 3/5/09 BG = 146, and 3/6/09 "Hosp [Hospital]" was documented. The 7:00 AM dose of Novolog 15 Units was left blank, and not initialed as given for 3/3/09 and 3/4/09; was documented "Held" for 3/5/09 and had a handwritten note "DC'd [discontinued] 3/6/09 See New order".</p> <p>On the MAR the 11:30 AM Novolog dose was left blank, and not initialed as given for 3/4/09. The 4:00 PM dose of Novolog and the 9:00 PM dose of Lantus were initialed as given for 3/4/09. The 3/5/09 date documented the 7:00 AM dose of Novolog was "Held", the 11:30 AM dose was initialed as given, and the 4:00 PM dose was left blank as not given. There was no documentation that the BG results were faxed to the attending physician as ordered. Review of the nurses' notes for 3/5/09 at 3:30 PM, documented "...res. [resident] noted to be unresponsive, diaphoretic [diaphoretic], et [and] res. blood sugar 34..." On 3/5/09 Resident #14 was sent to the hospital and admitted.</p> <p>Resident #14 was readmitted to the facility on 3/6/09 with changes of insulin orders noted on above Hospital Transfer "Physician Orders" dated 3/6/09.</p> <p>Review of Resident #14's BG flow sheets for "March 09" documented no BG levels for 3/4 and 3/5/09. The BG flow sheets for 3/7/09 through 3/21/09 documented 60 opportunities for the BG to be checked. There were 3 opportunities with no documentation that the BG had been obtained as</p>	F 333	<p>The Director of Nursing and the Nurse Consultant are doing a daily audit of actual insulin administration in relation to meal times and the results recorded. This will be done daily for 2 weeks and then weekly for 2 weeks and then quarterly for the next 12 months.</p> <p>The results of the audits will be reported to the QA committee weekly for 4 weeks and then quarterly for the next 12 months. The QA committee, comprised of the Administrator, the Director of Nursing, the Medical Director, Dietician /food service manager, the Pharmacy Consultant, the Social Services director, the Activity director, the environmental services director, the MDS coordinator, and others as appointed by the administrator, will make any needed changes to the plan .</p>		

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F 333	<p>Continued From page 53</p> <p>ordered (the spaces were blank). Resident #14's BG ranged from a low of 54 on 3/8/09 at 9:00 PM to a high of 541 on 3/15/09 at 8:00 PM.</p> <p>Review of the nurses note dated 3/11/09 at 7:20 AM, documented "...Resident [#14] found...in floor in room by bed... Assisted out of floor...resident became diaphoretic. BG checked - 56...called and got orders from Dr. [named physician] ...IV started ...D5W [Dextrose 5 percent water] @ 70 infusing..." signed by Registered Nurse #11.</p> <p>An undated telephone order signed by Registered Nurse #11 at 8:30 AM and signed by the physician on 4/13/09 documented "...D5W @ 70 cc [cubic centimeter] / [per] hr [hour] until BG over 300 then D/C... Blood glucose Q2 [every two hours] X [times] 24 [hours]... Hold all insulin for now... [change] Lantus to Levimir 20U [units] @ HS & 10 U in am..."</p> <p>In review of this telephone order signed by the physician on 4/13/09, the reviewer would have no knowledge that the telephone order was given on 3/11/09 until review of the nurses notes of 3/11/09 at 7:20 AM that documented the nurse called the physician and "got orders ...IV started ...D5W @ 70 infusing ..." and both telephone order and nurses note were signed by Registered Nurse #11.</p> <p>Review of the BG flow sheets documented the every two hour BG was obtained on 3/11/09 from 8:30 AM until 10:30 PM. The BG was 81 at 8:30 AM, 160 at 10:30 AM, 342 at 12:30 PM (D5W infusion was stopped), 496 at 2:30 PM, 493 at 4:30 PM, 302 at 6:30 PM, 129 at 8:30 PM, 96 at 10:30 PM. There was no documentation that the Q2 hour BS was obtained after 10:30 PM on</p>	F 333		
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NAME OF PROVIDER OR SUPPLIER BAILEY PARK CLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 MITCHELL STREET HUMBOLDT, TN 38343	
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F 333	<p>Continued From page 54</p> <p>3/11/09. The next BG taken was documented on 3/12/09 as 126 at 6 AM, 197 at 11:00 AM, 279 at 4:30 PM and 404 at 8:30 PM.</p> <p>Review of Resident #14's March 2009 MAR documented that Levimir 10 U in AM was given at 6 AM from 3/13 through 3/31/09. Levimir 10 U at 6 AM should have been given on 3/12/09, but the space is blank. Levimir 20 U at HS was documented given at 8 PM from 3/16 through 3/29/09; a blank space was noted on 3/30/09; and then documented given on 3/31/09. Levimir 20 U at HS should have been given from 3/11/09 through 3/15/09, but the spaces are blank for these dates.</p> <p>Review of the March 2009 MAR documented physician ordered (3/6/09) scheduled Novolog 12 U before breakfast, lunch & supper was not given on 3/12 to 13/09 as ordered and not given before breakfast on 3/14/09. A hand-written note documented the scheduled Novolog was "DC'd 3-21-09." The telephone order of 3/11/09 changing the long acting Lantus to Levimir did not address the shorter acting scheduled 12 U of Novolog before breakfast, lunch and supper. The new phone order on 3/21/09 for Novolog sliding scale insulin was not followed from 3/21/09 through 3/25/09 at 6 AM. Instead, the scheduled dose of Novolog 12 U was given from 3/21/09 from to 3/25/09.</p> <p>Review of the March 2009 patient record log documented BG as follows:</p> <ul style="list-style-type: none"> a. 3/13/09 at 9:00 PM - BG = 532, Novolog 14U given, no order for this insulin administered. b. 3/14/09 at 3:00 PM - BG = 510, Novolog 14U given, no order for this insulin administered. c. 3/15/09 at 8:00 PM - BG = 541, Novolog 14U 	F 333		

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F 333	<p>Continued From page 55</p> <p>given, no order for this insulin administered. The administration of insulin without an order resulted in significant medication errors.</p> <p>Review of a telephone order dated 3/21/09 for Resident #14 documented "...NO [new order] for Novolog sliding scale [SSI] 150- 200 [administer] 4U, 201-250 6U...251-300 8U, 301-350 10U, 351-400 12U, 450 & ^ 14 units & above 450 monitor q 4 [hours]..." There was no order for an insulin dose for a BG between 401 and 449. The staff failed to follow the facility's diabetic therapeutic protocol of notifying the physician if no sliding scale insulin is ordered.</p> <p>Review of Resident #14's blood sugar flow sheet for 3/22/09 through 3/31/09 documented 40 opportunities for the BG to be checked. The BG ranged from 99 on 3/24/09 at 8:00 PM to 481 on 3/26/09 at 9:00 PM. There were 8 times with the wrong doses of insulin being given. The BG with the incorrect SSI was as follows:</p> <p>a. 3/23/09 at 5:00 PM - BG = 326, Insulin given = 12U, correct dose = 10U.</p> <p>b. 3/23/09 at 9:00 PM - BG = 209, Insulin given = 12U, correct dose = 6U.</p> <p>c. 3/24/09 at 11:00 AM - BG = 162, Insulin given = 12U, correct dose = 4U.</p> <p>d. 3/24/09 at 5:00 PM - BG = 229, Insulin given = 12U, correct dose = 6U.</p> <p>e. 3/25/09 at 9:00 PM - BG = 262, Insulin given = blank space - no documentation of SSI given, correct dose = 8U.</p> <p>f. 3/29/09 at 9:00 PM - BG = 466, Insulin given = No documentation the SSI was given, correct dose Novolog 14U.</p> <p>g. 3/30/09 at 6:00 AM - BG = 259, Insulin given = blank space - no documentation of SSI given, correct dose = 8U.</p>	F 333		

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F 333	<p>Continued From page 56</p> <p>h. 3/31/09 at 8:00 PM - BG = 423, Insulin given = 14U. There was no order for insulin to be given for this blood sugar level. The administration of the wrong insulin and wrong insulin doses of insulin resulted in significant medication errors.</p> <p>Review of Resident #14's physician orders dated 8/1/09 documented "...LEVIMIR INSULIN 20u q am ... ACCUCHECK AC AND HS SS [sliding scale] NOVLOG INSULIN ... 150-200 4U ...201-250 6 U ...251-300 8U ...301-350 10U ...351-400 15 U ... [No physician order for Novolog sliding scale insulin for BG range of 401-450] ...451-14U AND MONITOR Q 4 HRS TIL [until] STABLE..." There was no physician order for Levimir Insulin 25 U HS that was hand written onto the August 2009 MAR. There was no documentation that the physician was notified that there were no orders for SS insulin for a BG range of 401-450 nor was a physician order obtained for SS Insulin for BG levels within the range of 401-450.</p> <p>Review of Resident #14's August 2009 MAR documented 24 doses of Levimir 25 U insulin given at 9:00 PM without an order for Levimir 25 U HS. This resulted in significant medication errors. There was one instance of the wrong sliding scale insulin given (Humalog instead of the physician ordered Novolog), on 8/14/09 at 4 PM. This resulted in a significant medication error.</p> <p>Review of Resident #14's August 2009 BG flow sheets documented 124 opportunities for BG to be checked. There were 4 opportunities for BG to be checked with no documentation that a BG was obtained. The BG ranged from a low of 58 on 8/14/09 at 8:00 PM to a high of 517 on 8/20/09 at 11:00 AM. Significant medication errors with</p>	F 333		
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F 333	Continued From page 57 physician ordered sliding scale insulin noted on the August 2009 BG flow sheets are as follows: a. 8/2/09 at 8:00 PM - BG = 158, Insulin given = "Levimir given", no physician's order for this insulin and no documentation of Novolog sliding scale insulin given as ordered, correct dose = 4U. b. 8/4/09 at 4:00 PM - BG = 416, Insulin given = 14U. There was no order for sliding scale insulin to be given for a BG of 401-450. c. 8/6/09 at 4:00 PM - BG = 404, Insulin given = 15U. There was no order for sliding scale insulin to be given for a BG of 401-450. d. 8/7/09 at 8:00 PM - BG = 231, Insulin given = "Levimir [25 U]", no physician's order for this insulin and no documentation of Novolog sliding scale insulin given as ordered, correct dose = 6U. e. 8/11/09 at 8:30 PM - BG = 231, Insulin given = "Levimir [25U]", no physician's order for this insulin and no documentation of Novolog sliding scale insulin given as ordered, correct dose = 6U. f. 8/14/09 at 4:00 PM - BG = 507, Insulin given = There was a blank space with no documentation of Novolog sliding scale insulin given as ordered, correct dose = 14U. g. 8/14/09 at 4:00 PM - BG = 448, Insulin given = Humalog 15U. The wrong insulin was administered; there is no physician order for Humalog insulin to be administered. The physician order was for Novolog sliding scale insulin but the physician order did not address the amount of Novolog sliding scale insulin to be given for a BG range of 401-450. h. 8/15/09 at 8:00 PM - BG = 251, Insulin given = "Levimir given [25 U]", no physician's order for this insulin and no documentation of Novolog sliding scale insulin given as ordered, correct dose = 8U. i. 8/16/09 at 8:00 PM - BG = 348, Insulin given = "Levimir given [25 U]", no physician's order for	F 333		

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F 333	<p>Continued From page 58</p> <p>this insulin and no documentation of Novolog sliding scale insulin given as ordered, correct dose = 10U.</p> <p>j. 8/18/09 at 8:00 PM - BG = 234, Insulin given = 8U, correct dose = 6U.</p> <p>k. 8/19/09 at 4:00 PM - BG = 424, Insulin given = 15U. There was no order for Novolog sliding scale insulin to be given for BG range of 401-450.</p> <p>l. 8/21/09 at 4:00 PM - BG = 410, Insulin given = 15U. There was no order for sliding scale insulin to be given for BG range of 401-450.</p> <p>m. 8/24/09 at 6:00 AM - BG = 152, Insulin given = "0 [no Novolog sliding scale insulin given] held pt [patient] "brittle", correct dose = 4U.</p> <p>n. 8/24/09 at 4:00 PM - BG = 445, Insulin given = 15U. There was no order for Novolog sliding scale insulin to be given for BG range of 401-450.</p> <p>o. 8/25/09 at 4:00 PM - BG = 247; Insulin given = There was a blank space with no documentation of Novolog sliding scale insulin given as ordered, correct dose = 6U.</p> <p>p. 8/25/09 at 8:00 PM - BG = 151, Insulin given = "0 [0 units]", correct dose = 4U.</p> <p>q. 8/29/09 at 4:00 PM - BG = 224, Insulin given = There was a blank space with no documentation of Novolog sliding scale insulin given as ordered, correct dose = 6U.</p> <p>The administration of the wrong insulin (Humalog), administration of wrong insulin doses of Novolog sliding scale insulin, Novolog sliding scale insulin not administered as ordered when the BG level required administration of insulin and the administration of insulin for a BG of 401-450 without physician orders for this range of BG, resulted in significant medication errors.</p> <p>Levimir long acting insulin 25 U was documented to be given 5 times by the same Nurse #10, on the evening shift at 8 PM and 8:30 PM, with no</p>	F 333		
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F 333	<p>Continued From page 59</p> <p>physician orders for Levimir 25 U HS. There was no documentation of Novolog sliding scale insulin administered per physician orders for (5 times) 8/2, 8/7, 8/11, 8/15, and 8/16/09.</p> <p>Review of Resident #14's nurses' notes dated 8/14/09 documented "...Accu [check] @ 4PM = 448 SS coverage given accu [check] @ 8pm 58..." There was no order to give SSI for the BG of 448.</p> <p>A nurses' note dated 9/11/09 at 11:30 PM for Resident #14 documented, "...Found diaphoretic, pale & lethargic. Blood sugar checked c result of 22. Accucheck again -- "too low to be read" ... Ambulance called, report given... 9/12/09 3AM... RTF [return to facility] per ambulance c [with] new MD orders--Skin warm & dry - Color pale..."</p> <p>Review of Resident #14's recertification physician's orders dated 9/2/09 documented, "Levemir 25 Units Subcutaneous Every HS At 9 PM For Diabetes... Levimir Insulin 20 u Q AM... Accuchecks AC and HS SS Novolog Insulin 150-200=4u, 201-250=6u, 251-300=8u, 301-350=10u, 351-400=15u, 451-14u And Monitor Q [every] 4 HRS Til [until] Stable..."</p> <p>Review of a telephone order dated 9/11/09 documented, "...[decrease] Levemir Insulin to 12 units @ hs." Review of a Return to Facility (RTF) orders dated 9/12/09 documented, "...2. Change Novolog Insulin sliding scale subcut [subcutaneous] 150-200=4units, 201-250=6units, 251-300=8units, 301-350=10units, 351-400=12 units, 401 or greater=14 units and monitor Q4 hours til stable and notify MD."</p> <p>A nurses' notes dated 9/11/09 at 11:30 PM documented, "[Resident #14] Found diaphoretic,</p>	F 333			

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F 333	<p>Continued From page 60</p> <p>pale & lethargic. Blood sugar checked c result of 22. Accucheck again--'too low to read'...Ambulance called..." The 9/11/09 nurses' noted documented a low BG of 22. The resident was exhibiting signs and symptoms of hypoglycemia (a low BG).</p> <p>Review of Resident #14's September 2009 MAR documented that Levimir was administered at the wrong dose on 2 occasions for the PM dosage. Review of Resident #14's September 2009 BG flow sheet documented 120 opportunities for the BG to be checked. There were 18 with the wrong doses of insulin given. The BG ranged from a low of 62 on 9/8/09 at 11:00 AM to a high of 467 on 9/23/09 at 4:00 PM. The BG with the incorrect SSI were as follows:</p> <p>a. 9/2/09 at 4:00 PM - BG = 241, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 6U.</p> <p>b. 9/2/09 at 8:00 PM - BG = 208, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 6U.</p> <p>c. 9/7/09 at 6:00 AM - BG = 165, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 4U.</p> <p>d. 9/8/09 at 4:00 PM - BG = 229, insulin that was documented as given = 4U, correct dose = 6U.</p> <p>e. 9/8/09 at 8:00 PM - BG = no documentation that a BG was obtained.</p> <p>f. 9/12/09 at 6:00 AM - BG = 317, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 10U.</p> <p>g. 9/12/09 at 8:00 PM - BG = 264, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 8U.</p> <p>h. 9/13/09 at 4:00 PM - BG = 289, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 8U.</p>	F 333		
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F 333	Continued From page 61 i. 9/14/09 at 4:00 PM - BG = 155, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 4U. j. 9/14/09 at 4:00 PM - BG = 307, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 10U. k. 9/15/09 at 6:00 AM - BG = 230, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 6U. l. 9/16/09 at 8:00 PM - BG = 239, Insulin given = 25U Levimir. The order for Scheduled PM Levimir was for 12u. The documented 25u Levimir given was a wrong dose and the correct dose of SS = 8U Novolog. No SS Insulin was documented as given on the MAR or the BG flow sheet. m. 9/17/09 at 4:00 PM - BG = 269, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 8U. n. 9/17/09 at 8:00 PM - BG = 176, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 4U. o. 9/18/09 at 6:00 AM - BG = 201, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 6U. p. 9/20/09 at 6:00 AM - BG = 215, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 6U. q. 9/26/09 at 8:00 PM - BG = 306, Insulin given = 20U Levimir. The order for Scheduled PM Levimir was for 12u. The documented 20u Levimir given was a wrong dose and the correct dose of SS = 10U Novolog. No SS Insulin was documented as given on the MAR or on the BG flow sheet. r. 9/27/09 at 9:00 PM - BG = 204, Insulin given = 12U Levimir. The resident should have received 6 units of Novolog but there was no documentation any Novolog was given. The administration of the wrong insulin in addition to the wrong insulin doses resulted in significant	F 333		

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F 333	Continued From page 62 medication errors. Review of Resident 14's laboratory HGB A1C (blood teste gives the average of the blood sugars levels for a 3 month period) dated 9/30/09 documented, "Test>HGB A1C, Result=8.2, Flag H [High A1C level], Reference=4.2-5.8. It was documented on the laboratory results form, "Faxed to DR [doctor] 10/6/09 @ [at] 3:15 PM" (6 days after the result was received). There was no documentation the MD was notified timely of the high HGB A1C level. Review of Resident #14's physician's orders dated 10/21/09 documented "...LEVIMIR INSULIN 20U Q AM..." and an order initiated 9/12/09 for "...ACCUCHECKS AC AND HS WITH SLIDING SCALE INSULIN NOVOLOG 0-149= [amount of insulin to be administered] 0 UNITS, 150-200=4 UNITS, 201-250=6 UNITS, 251-300=8 UNITS, 301-350=10 UNITS, 351-400=12 UNITS, 401 OR GREATER=14 UNITS AND MONITOR Q 4 HOURS UNTIL STABLE AND NOTIFY MD..." Review of Resident #14's October 2009 MAR documented that Levimir 12 units was administered at 8:00 PM from 10/21/09 through 10/31/09 without an order. Review of the October 2009 BG flow sheet documented 124 opportunities for BG to be checked. The BG ranged from a high of 394 on 10/15/09 at 9:00 PM to a low of 74 on 10/24/09 at 4:00 PM. There were 16 with the wrong doses of insulin given. The BG with the incorrect SSI were as follows: a. 10/2/09 at 11:00 AM - BG = 214, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 6U. b. 10/5/09 at 9:00 PM - BG = 308, Insulin given = No documentation on the MAR or BG flow sheet	F 333		

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F 333	Continued From page 63 of SS insulin given. The correct dose = 10U Novolog. c. 10/6/09 at 6:00 AM - BG = 332, Insulin given = 8U, correct dose = 10U. d. 10/9/09 at 6:00 AM - BG = 150, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 4U. e. 10/10/09 at 6:00 AM - BG = 150, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 4U. f. 10/11/09 at 11:00 AM - BG = 267, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 8U. g. 10/15/09 at 6:00 AM - BG = 251, Insulin given = 6U, correct dose = 8U. h. 10/15/09 at 9:00 PM - BG = 159, Insulin given = No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 4U. i. 10/16/09 at 11:00 AM - BG = 312, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 10U. j. 10/18/09 at 6:00 AM - BG = 261, Insulin given = 6U, correct dose = 8U. k. 10/20/09 at 4:00 PM - BG = 300, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 8U. l. 10/21/09 at 11:00 AM - BG = 370, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 12U. m. 10/21/09 at 4:00 PM - BG = 260, No amount of SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 8U. n. 10/21/09 at 9:00 PM - BG = 178, No SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 4U. o. 10/25/09 at 9:00 PM - BG = 394, Insulin given = 14U, correct dose = 12U. p. 10/29/09 at 11:00 AM - BG = 215, No SS Insulin was documented as given on the MAR or	F 333		

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F 333	<p>Continued From page 64</p> <p>on the BG flow sheet, correct dose = 6U. The administration of the wrong insulin doses resulted in significant medication errors.</p> <p>Review of Resident #14's physician's orders dated 11/2/09 documented the same insulin orders as for October 2009. There were 32 opportunities for the BG to be checked from 11/1/09 through 11/9/09. There were three times with the wrong doses of insulin given. The BG with the incorrect SSI given were as follows:</p> <p>a. 11/3/09 at 11:00 AM - BG = 229, No amount of SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 6U.</p> <p>b. 11/6/09 at 6:00 AM - BG = 178, No amount of SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 4U.</p> <p>c. 11/9/09 at 11:00 AM - BG = 230, No amount of SS Insulin was documented as given on the MAR or on the BG flow sheet, correct dose = 6U.</p> <p>The administration of the wrong insulin doses resulted in significant medication errors.</p> <p>During an interview in the conference room on 11/11/09 at 9:10 AM, Nurse #8 was asked if the facility had provided any inservices regarding insulins and how insulins should be administered, "None before you [surveyors] got here... Now, they [the facility] wants to put it [accuchecks and morning insulin administration] on us [the day shift nurses]... This morning [11/11/09] they changed it to give [morning insulins] at 7 AM... They won't listen to me... They have just made these changes to impress you... [Named Resident #14] is everywhere [blood glucose high and low]... He is a bad diabetic... I asked [named the Director of Nursing] why did we [day shift] have to do his accuchecks and give insulin. Why couldn't the night shift keep doing it? And she told</p>	F 333		

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F 333	<p>Continued From page 65</p> <p>me it was because we would have weight loss all over the place, because the night shift would be giving sandwiches and snacks with the insulin and the resident might not eat their breakfast."</p> <p>Review of the "MED-PASS" provided by the American Society of Consultant Pharmacists for typical dosing administration related to meals documented "...Novolog... [administer] 5- [to] 10 minutes before meals... "</p> <p>Observations during medication administration in Resident #14's room on 11/9/09 at 3:50 PM, revealed Nurse #4 obtained a BG of 332. Nurse #2 administered 10 units of Novolog insulin to Resident #14 at 4:14 PM. Resident #14 had not received his dinner meal at 5:15 PM, one hour after the fast acting insulin was given.</p> <p>During an interview in the conference room on 11/11/09 at 8:35 AM, the Consultant Pharmacist was asked how long he had been consulting with this facility, how often did he come to the facility and what was he responsible for. The Consultant Pharmacist (CP) stated, "I have been coming here pretty close to a year... I am here once a month... I do general medication reviews..." The surveyor asked the CP if he had done any inservices with the nursing staff. The CP stated, "I have not done any recently due to the turn over [with staff]..." The surveyor asked the CP what charts did he review, what did he look at and how often. The CP stated, "Monthly...I look at every chart in the building...chart reviews, I look at allergies, labs and anything to do with medications..." The CP was asked if he had found any problems with insulins. The CP stated, "No, I have not... Me and [named the DON] did discuss the timing of insulins... the [Hemoglobin] A1Cs [a</p>	F 333		
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F 333	<p>Continued From page 66</p> <p>blood glucose test that averages blood glucose for 3 months] have been good..." The CP was asked if he had found in his review any holes/blanks in the MAR. The CP stated, "One hole is too many... I just don't know how to enforce making the nurses scared to leave holes..." The CP was asked if he had attended the facility's Quality Assurance (QA) meetings. The CP stated, "They have not requested me at QA." The CP was asked if he reviewed the residents' orders and recertification orders. The CP stated, "I do not review every single order... No...There are some [orders] that do not get documented accurately." The CP was asked if he was aware of any serious problems with the recertification orders. The CP stated, "Well, they have a serious problem with staffing... Every month it is different nurses..." The CP was asked if he felt there was a problem at this facility. The CP stated, "Absolutely... Staffing has been a huge issue..."</p> <p>Review of the Consultant Pharmacist Review sheet for 3/20/09 through 10/23/09 had no documentation of the identified concerns with insulin administration as noted above for Resident #14, yet the pharmacist stated he reviewed every chart.</p> <p>The surveyors attempted to contact the Medical Director on 11/11/09. The Medical Director returned the call to the state office on 11/12/09 at 10:15 AM. The Medical Director, who is also Resident #14's attending physician, was asked when he would expect to be notified of blood glucose (BG) levels. The physician stated, "...Certainly if it's greater than 400 or 450 they [staff] need to notify me... if below 60 notify me..." The Medical Director was asked if he reviews the</p>	F 333		

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F 333	<p>Continued From page 67</p> <p>resident's BG flow sheets. The Medical Director stated, "...I review the [Hemoglobin] A1C ...not the flow sheets...The flow sheet is more for nursing..."</p> <p>3. Medical record review for Resident #4 documented an admission date of 2/26/09 with a readmission date of 10/1/09 with current diagnoses of Diabetes, Aphasia, Hypertension, Convulsions, Stroke with Hemiparesis and Dementia. Review of Resident #4's August 2009 physician's order documented, "...NOVOLIN R PER SLIDING SCALE AC AND HS 151-200 3U, 201-250 5U..."</p> <p>Review of Resident #4's August 2009 MAR and the patient record log/request for treatment plan documented the following:</p> <p>a. 8/10/09 at 8:00 PM - BG 223, no SSI was documented as given, correct dose was 5U.</p> <p>b. 8/16/09 at 8:00 PM - BG 167, no documentation that SSI was given, correct dose was 3U. The failure to administer the ordered SSI resulted in significant medication errors.</p> <p>Review of Resident #4's physician's orders dated 9/11/09 documented, "...OBTAIN ACCUCHECKS Q AM AT 6 AM WITH SSI NOVOLIN R ...151-200 =3U..."</p> <p>Review of Resident #4's September 2009 MAR and the patient record log/request for treatment plan documented the following:</p> <p>a. 9/25/09 at 6:00 AM - BG 175, no documentation that SSI was given, correct dose was 3U.</p> <p>b. 9/26/09 at 6:00 AM - BG 187, no documentation that SSI was given, correct dose was 3U.</p> <p>c. 9/27/09 at 6:00 AM - BG 160, no</p>	F 333		
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F 333	Continued From page 68 documentation that SSI was given, correct dose was 3U. d. 9/30/09 at 6:00 AM - BG 168, no documentation that SSI was given, correct dose was 3U. The failure to administer the ordered SSI resulted in significant medication errors. The surveyors attempted to contact the Physician for Resident #4 on 11/11/09. The The Physician for Resident #4 returned the call to the state office on 11/12/09 at 4:40 PM. The Attending Physician for Resident #4 verified that he was not aware of any problems with insulin regarding his residents in recent times.	F 333		
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced	F 425	F425 1. Resident # 14 's eye drops are now available and being given as ordered. The medication was in the med cart on 11/19/09. Validated by the DON on 11/19/09. 2. Other residents with the potential to be affected were identified through a reconciliation of the reviewed physician's orders and the medication available in the med carts by the Director of Nursing and the Nurse consultant on 11/19/09. Medications were obtained as needed. 3. Licensed nursing staff was in serviced on ensuring medication availability and medication ordering by the Director of Nursing on 11/19/09. Nurses not in serviced on this date will be in serviced prior to returning to duty . No agency nurses are utilized at this time. In-service will be conducted upon hire and annually thereafter. Agency nurses will be in serviced prior to working. These in-services will be conducted by the Director of Nursing or the RN supervisor.	11-25-09

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F 425	Continued From page 69 by: Based on medical record review, it was determined the facility failed to provide pharmaceutical services to ensure prescribed medications were administered as ordered for 1 of 18 (Resident #14) sampled residents. The findings included: Medical record review for Resident #14 documented an admission date of 2/26/09 with a diagnosis of Diabetes Mellitus Type 2, Mood disorder, Disorders of the Thyroid, Suicidal Ideation, Diabetic Retinopathy, Lack of Coordination and Abnormality of Gait. A physician's order dated 8/1/09 documented, "Xalatan 0.005% [percent] Eye Drops One GTT [drop] OU [both] eyes Q [every] HS [night]..." Review of the August 2009 Medication Administration Record (MAR) revealed the Xalatan eye drops was circled as not given on August 1st through 13th. documentation on the back of the August 2009 MAR revealed "8/13/09 8P [PM] Xalatan 0.005% eye gtts-not given-not here, ordered from pharmacy." The facility failed to ensure Resident #14's Xalatan eye drop medication was available when ordered.	F 425	The RN supervisors will check medication availability 3 times per week and order medication as needed ongoing. A medication availability audit tool was created by the NC on 11/19/09. 4. The RN supervisors will complete the medication availability audit tool 3 times a week ongoing. The Director of Nursing will review the results of the audits on a weekly basis for 3months and the quarterly for the next 12 months. The results of the audits will be reported to the QA committee monthly for 3 months and then quarterly for the next 12 months. The QA committee, comprised of the Administrator, the Director of Nursing, the Medical Director, Dietician /food service manager, the Pharmacy Consultant, the Social Services director, the Activity director the environmental services director, the MDS coordinator, and others as appointed by the administrator, will make any needed changes to the plan .	
F 428 SS=J	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	F428 1. Residents # 11, # 14 #15, and #18 and Random residents #1,#3, #4, and # 5 are receiving medication correctly and consistently, within the proper time frame, and according to current physicians orders as of 11/13/09.	11-20-09

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F 425	<p>Continued From page 69</p> <p>by: Based on medical record review, it was determined the facility failed to provide pharmaceutical services to ensure prescribed medications were administered as ordered for 1 of 18 (Resident #14) sampled residents.</p> <p>The findings included:</p> <p>Medical record review for Resident #14 documented an admission date of 2/26/09 with a diagnosis of Diabetes Mellitus Type 2, Mood disorder, Disorders of the Thyroid, Suicidal Ideation, Diabetic Retinopathy, Lack of Coordination and Abnormality of Gait. A physician's order dated 8/1/09 documented: "Xalatan 0.005% [percent] Eye Drops One GTT [drop] OU [both] eyes Q [every] HS [night]..." Review of the August 2009 Medication Administration Record (MAR) revealed the Xalatan eye drops was circled as not given on August 1st through 13th. documentation on the back of the August 2009 MAR revealed "8/13/09 8P [PM] Xalatan 0.005% eye gtt-not given-not here, ordered from pharmacy." The facility failed to ensure Resident #14's Xalatan eye drop medication was available when ordered.</p>	F 425		
F 428 SS=J	<p>483.60(c) DRUG REGIMEN REVIEW</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p>	F 428	<p>1. Residents # 11, # 14 #15, and #18 and Random residents #1, #3, #4, and # 5 are receiving medication correctly and consistently, within the proper time frame, and according to current physicians orders as of 11/13/09. This was verified by the DON thru observation and record review.</p>	11-20-09

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F 428	<p>Continued From page 70</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the facility's "Pharmacy Services Agreement Terms and Conditions", medical record review, observations and interviews, it was determined that the Consulting Pharmacist failed to monitor, review and identify medications that were not administered correctly, that fast acting insulins (insulin that reaches it's peak effect in 15 to 30 minutes) were not administered correctly and that there were no blanks on the Medication Administration Records (MAR) (indicating the insulin was not administered at all) for 4 of 18 (Residents #11, 14, 15 and 18) sampled residents and 4 Random Residents (RR #1, 3, 4 and 5). The pharmacy consultant failed to ensure nursing staff administered insulin within the proper time frame before a meal, administer the correct amount of insulin according to the sliding scale and/or failed to obtain orders for insulin administration which resulted in conditions that were likely to be serious and immediate threat to the health of 2 of 7 (Residents #4 and 14) sampled diabetic residents. The facility failed to ensure that ordered medications were available for 1 of 18 (Residents #14) sampled residents. A conference was held in the conference room on 11/10/09 at 4:45 PM, at which time the Administrator and Director of Nursing (DON) were informed of the findings that are, or are likely to place diabetic residents in a serious and immediate threat to their health. The insulin dependent diabetics have the high likelihood of having hypoglycemia and hyperglycemia episodes by receiving the wrong insulin or the wrong insulin doses. This placed the diabetic residents in immediate jeopardy (IJ). The</p>	F 428	<p>The pharmacy consultant reviewed Residents # 11,#14,# #15, and 18 and Random Residents 1,3,4, and 5 medication regimen on 11/13/09 and recommendations were made and sent to the physician on 11/13/09. The Administrator re-educated the pharmacy consultant on 11/12/09 regarding the expectations of a monthly medication regimen review for all residents and identification and reporting of medications being administered correctly and consistently, timing of insulin in relation to meals, the correct dosage of insulin, the correct insulin, ranges of SSI and physicians orders for medication. Resident 14 has all ordered medication available.</p> <p>2. All residents have the potential to be effected. The pharmacy consultant completed a medication regimen review for all residents on 11/13/09 and recommendations were made and sent to physicians. Correct</p>	
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F 428	<p>Continued From page 71 IJ effective date is 11/10/09, and is ongoing until the IJ is removed.</p> <p>The findings included:</p> <p>1. Review of the facility's "Pharmacy Services Agreement Terms and Conditions" documented, "1. Consulting Services...provides ...the following services at the Facility: (a) Once each month, consult with the Facility's staff as to each resident's drug regimen and provide a written report of concerns of inappropriate utilization patterns (if any) to the Facility's administrator, Director of Nursing Services or the resident's physician, as appropriate. (b) Consult with the Facility's staff as to its creation and maintenance of its Pharmacy Policy and Procedure Manual, including (without limitation) its creation and implementation of policies and procedures in respect of the distribution, control and use of prescription drugs in the Facility... (d) Once each month, observe a medication pass from the Facility to a patient, and note concerns related to quality assurance (if any) to the Facility's Administrator... (f) Using its pharmacy staff, coordinate and conduct two educational programs on pharmacy issues (each one-hour long) for the Facility's staff. (g) Once each month, attend a meeting with the Administrator and Director of Nursing at each Facility to discuss Pharmacy issues. (h) On Facility's request (but not more than once per calendar quarter), serve (in an advisory role) on the Facility's Quality Assurance and Assessment Committee..."</p> <p>During an interview in the conference room on 11/11/09 at 8:35 AM, the Consultant Pharmacist was asked how long he had been consulting with this facility, how often did he come to the facility</p>	F 428	<p>insulin type was included where applicable. A medication/ MAR reconciliation to ensure meds available was done by the DON and NC,RN on 11/19/09 and meds ordered if needed.</p> <p>3. The pharmacy consultant will complete a medication regimen review and make recommendations to the physicians on a monthly basis. The Pharmacy consultant will conduct a med pass with 2 nurses monthly ongoing and review the MARs for completeness. <u>The pharmacy consultant will rotate shifts monthly for med pass observation.</u></p> <p>The Pharmacy consultant will be notified of the dates and times of the QA meeting by the Administrator and will attend the QA meetings to report on concerns.</p> <p>The RN supervisors will conduct a medication/MAR reconciliation on Sunday, Tuesday, and Thursday</p>	

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F 428	<p>Continued From page 72</p> <p>and what was he responsible for. The Consultant Pharmacist (CP) stated, "I have been coming here pretty close to a year... I am here once a month... I do general medication reviews..." The surveyor asked the CP if he had done any inservices with the nursing staff. The CP stated, "I have not done any recently due to the turn over [with staff]..." The surveyor asked the CP what charts did he review, what did he look at and how often. The CP stated, "Monthly...I look at every chart in the building...chart reviews, I look at allergies, labs and anything to do with medications..." The CP was asked if he had found any problems with insulins. The CP stated, "No, I have not... Me and [named the DON] did discuss the timing of insulins... the [hemoglobin] A1Cs [laboratory test that measures the average of the blood glucose levels over a three month period] have been good..." The CP was asked if he had found in his review any holes/blanks in the MAR. The CP stated, "One hole is too many... I just don't know how to enforce making the nurses scared to leave holes..." The CP was asked if he had attended the facility's Quality Assurance (QA) meetings. The CP stated, "They have not requested me at QA." The CP was asked if he reviewed the resident's orders and recertification orders. The CP stated, "I do not review every single order... No...There are some [orders] that do not get documented accurately." The CP was asked if he was aware of any serious problems with the recertification orders. The CP stated, "Well, they have a serious problem with staffing... Every month it is different nurses..." The CP was asked if he felt there was a problem at this facility. The CP stated, "Absolutely... Staffing has been a huge issue..."</p> <p>Review of the Consultant Pharmacist Review</p>	F 428	<p>ongoing and record the findings on the Medication Availability Audit Tool. The audit tool was created by the NC on 11/19/09 and is used to check the medication in the cart against the MAR and when the meds are ordered and received. The Audit Tool will be reviewed weekly by the Director of Nursing ongoing.</p> <p>4. The Pharmacy consultant will create a written report of findings on each visit. The ADM will complete the Quarterly Report quarterly to verify the Pharmacy consultant performance. The Director of Nursing will review the Pharmacy report for accuracy and completeness on a monthly basis and the Med Availability Audit weekly and report any findings to the QA committee weekly for 4 weeks and then quarterly. The QA committee, comprised of the Administrator, the Director of Nursing, the Medical Director, Dietician /food service manager, the Pharmacy Consultant, the Social Services director, the Activity director,</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445339	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/11/2009
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F 428	Continued From page 73 sheet for 3/20/09 through 10/23/09 had no documentation of the identified concerns with insulin administration for Resident #14, yet the pharmacist stated he reviewed every chart. Refer to F333. 2. The pharmacy consultant failed to observe administration of medications with the nursing staff or to conduct inservice training for the nursing staff to ensure a medication error rate was less than five percent (%). Five (5) of 7 nurses (Nurses #1, 3, 4, 5 and 7) made 11 errors out of 43 opportunities for error which resulted in a medication error rate of 25.58%. Three (3) of 3 shifts made medication errors. Refer to F332. 3. The pharmacy consultant failed to observe administration of medications, failed to review medication administration records, failed to review blood sugar flow sheets for completeness and accuracy of sliding scale insulins administered, failed to review the accuracy of recertification orders and failed to ensure that residents were free of significant medication errors. The pharmacy consultant failed to ensure nursing staff administered insulin within the proper time frame before a meal, administer the correct amount of insulin according to the sliding scale and/or failed to obtain orders for insulin administration which placed 2 of 7 (Residents #4 and 14) sampled diabetic residents in conditions that are, or are likely to place diabetic residents in a serious and immediate threat to their health. The insulin dependent diabetics have the high likelihood of having hypoglycemia and hyperglycemia episodes by receiving the wrong insulin or the wrong insulin doses. Refer to F333.	F 428	the environmental services director, the MDS coordinator, and others as appointed by the administrator, will make any needed changes to the plan. will make any needed changes to the plan.	
F 441 SS=E	483.65(a) INFECTION CONTROL	F 441		11-25-09

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F 428	Continued From page 73 sheet for 3/20/09 through 10/23/09 had no documentation of the identified concerns with insulin administration for Resident #14, yet the pharmacist stated he reviewed every chart. Refer to F333. 2. The pharmacy consultant failed to observe administration of medications with the nursing staff or to conduct inservice training for the nursing staff to ensure a medication error rate was less than five percent (%). Five (5) of 7 nurses (Nurses #1, 3, 4, 5 and 7) made 11 errors out of 43 opportunities for error which resulted in a medication error rate of 25.58%. Three (3) of 3 shifts made medication errors. Refer to F332. 3. The pharmacy consultant failed to observe administration of medications, failed to review medication administration records, failed to review blood sugar flow sheets for completeness and accuracy of sliding scale insulins administered, failed to review the accuracy of recertification orders and failed to ensure that residents were free of significant medication errors. The pharmacy consultant failed to ensure nursing staff administered insulin within the proper time frame before a meal, administer the correct amount of insulin according to the sliding scale and/or failed to obtain orders for insulin administration which placed 2 of 7 (Residents #4 and 14) sampled diabetic residents in conditions that are, or are likely to place diabetic residents in a serious and immediate threat to their health. The insulin dependent diabetics have the high likelihood of having hypoglycemia and hyperglycemia episodes by receiving the wrong insulin or the wrong insulin doses. Refer to F333.	F 428		
F 441 SS=E	483.65(a) INFECTION CONTROL	F 441		11-25-09

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F 441	<p>Continued From page 74</p> <p>The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and observations, it was determined 4 of 6 (Nurses #1, 3, 5 and 6) nurses observed administering medications failed to clean the glucometer between residents to prevent the possibility of cross contamination of blood and failed to perform proper handwashing to prevent the potential spread of infection.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Review of the facility's "Hand Washing" policy documented, "...wash hands before and after procedures... proper hand-washing techniques must be followed at all times... use disposable hand towel to turn off faucet." Observations during medication administration on 11/9/09 at 9:00 AM, Nurse #1 entered room 302, assisted the resident to lie down, gave the resident a tissue, administered eye drops in the resident's right eye while holding the lower lid with her left hand, administered eye drops in the resident's left eye, held the left eye lid with her left 	F 441	<p>F441</p> <ol style="list-style-type: none"> Glucometers were cleaned on 11/10/09 by the staff nurses . Nurse #1 and Nurse #3 were re-educated regarding handwashing on 11/12/09 by NC and an educated staff nurse. Nurse #5 and Nurse #6 have been re-educated regarding cleaning of the glucometer by the NC on 11/19/09. All residents have the potential to be affected regarding handwashing. Residents receiving finger stick blood glucoses per glucometer have the potential to be affected. Handwashing and skill competency was started on 11/12/09 and Glucometer cleaning inservice was done on 11/19/09 Nursing staff, dietary, maintenance, activity, SS, laundry, housekeeping, and administrative staff were in serviced regarding handwashing and a skill competency begun on 11/12/09 through 11/14/09 by the NC and staff nurse that was 	11-25-09
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F 441	<p>Continued From page 75</p> <p>index finger. Nurse #1 then washed her hands, turned the water off and dried her hands. Nurse did not wash hands after assisting the resident up in bed or prior to administering the eye drops.</p> <p>b. Observations during medication administration on 11/9/09 at 3:20 PM, Nurse #3 entered room 302 A to administer medications to the resident. Nurse #3 patted the resident from room 304 B on the back three times and then patted the resident from room 302 A two times on the back. Nurse #3 failed to wash her hands or use gel between these resident contacts.</p> <p>2. Review of the facility's "Recommendations for Cleaning and Disinfection of Glucometers" policy documented, "...CDC [Centers of Disease Control] states that HBV [Hepatitis B Virus] can survive for at least one week in dried blood on environmental surfaces or on contaminated instruments... disinfect after each use the exterior surfaces following the manufacturer's directions using a cloth/wipe with either an EPA -registered detergent / germicide with a tuberculocidal or HBV/HIV [Human Immunodeficiency Virus] label claim, or a dilute bleach solution of 1:10 (one part bleach to 9 parts water) to 1:100 concentration... Alcohol should never be used..."</p> <p>a. Observations during medication administration on 11/10/09 at 5:10 AM, Nurse #5 entered room 303 with the glucometer that was not observed clean before entering the room. The nurse placed the glucometer on the resident's overbed table without placing a barrier between the glucometer and the table. She placed a blood glucose test strip into the glucometer, stuck the resident's finger to obtain a drop of blood, placed the resident's blood sample onto the test strip and</p>	F 441	<p>educated prior by the NC. Handwashing was observed as part of the medication pass competency for licensed staff. Newly hired staff will be educated on the handwashing policy and skill competency upon hire and then annually thereafter. A glucometer cleaning policy and guideline was established on 11/18/09 by NC and approved by Administrator and DON on 11/19/09 . Handwashing competency will be done annually and upon hire. Newly hired licensed nursing staff will be informed of the glucometer cleaning policy and guideline upon hire.</p> <p>4. The Director of Nursing or RN supervisor will observe at least one nurse 5 times a week performing fingerstick blood glucoses for cleaning of the glucometer for 2 weeks, then weekly x 1 month and then quarterly for the next 12 months. The administrator will review newly hired nurses orientation checklists for glucometer training ongoing. The findings will be reported to the QA committee weekly for 2 weeks, then monthly</p>	

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F 441	Continued From page 76 the accucheck monitor displayed the resident's blood glucose reading. Nurse #5 failed to clean the glucometer after completing the procedure. At 5:31 AM, Nurse #5 entered room 103 with the glucometer that was not observed cleaned before entering the room. The nurse placed the glucometer on the resident's bedside table without placing a barrier between the glucometer and the table. She placed a blood glucose test strip into the glucometer, stuck the resident's finger to obtain a drop of blood, placed the resident's blood sample onto the test strip and the accucheck monitor displayed the resident's blood glucose reading. Nurse #5 failed to clean the glucometer after completing the procedure. Nurse #5 obtained blood samples from the residents and failed to clean the glucometer between each resident use. b. Observations during medication administration on 11/10/09 at 5:53 AM, Nurse #6 entered room 206 with the glucometer that was not observed clean before entering the room. The nurse placed the glucometer on the resident's overbed table without placing a barrier between the glucometer and the table. She placed a blood glucose test strip into the glucometer, stuck the resident's finger to obtain a drop of blood, placed the resident's blood sample onto the test strip and the accucheck monitor displayed the resident's blood glucose reading. Nurse #6 failed to clean the glucometer after using it. Nurse #6 placed the glucometer on the top of the medication cart. At 6:00 AM, Nurse #6 entered room 205 placed a box with the glucometer, test strips and lancets on the resident's bedside table. The glucometer was not observed cleaned before taking it into the resident's room for use. Nurse #6 did not place a	F 441	for one month and then quarterly The QA committee, comprised of the Administrator, the Director of Nursing, the Medical Director, Dietician /food service manager, the Pharmacy Consultant, the Social Services director, the Activity director, the environmental services director, the MDS coordinator, and others as appointed by the administrator, will make any needed changes to the plan .	

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F 441	Continued From page 77 barrier between the glucometer and the bedside table. She placed a blood glucose test strip into the glucometer, stuck the resident's finger to obtain a drop of blood, placed the resident's blood sample onto the test strip and the accucheck monitor displayed the resident's blood glucose reading. Nurse #6 failed to clean the glucometer after using it. Nurse #6 then left room 205 and placed the glucometer in an open box on top of the medication cart. Nurse #6 failed to clean the glucometer after using it. c. Each resident did not have their own glucometer. Each medication cart had one glucometer that was used for multiple residents. Each resident that had orders for finger stick blood glucose (BG) had a finger stuck with a lancet to obtain a blood sample to obtain a BG reading. The test strip is placed in the glucometer, the resident then will have a finger stick and a blood droplet will be dropped onto the strip. The blood could drop on the glucometer machine. The glucometer machines were not cleaned prior to being used nor were they cleaned between each resident use.	F 441		
F 490 SS=J	483.75 ADMINISTRATION 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 policy review, review of "MED-PASS" provided by the American Society of Consultant Pharmacists, review of the facility's "Pharmacy Services Agreement Terms and Conditions",	F 490	1. The Regional Director visited the facility on 11/11/09 to ensure that the facility is being administered effectively and efficiently. The Nurse Consultant has been in the facility with the Director of Nursing daily from 11/11/09 through 11/25/09 to ensure that the facility is being administered effectively and efficiently.	11-20-09

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F 490	Continued From page 78 medical record review, observations and interviews, it was determined the facility's administration including the Administrator and the Director of Nursing (DON) failed to effectively and efficiently ensure that the facility identified, monitored and followed-up on quality of care issues such as notifying the physician of elevated and/or low blood sugar (BS) levels. The facility's failure to notify the Medical Doctor (MD) of a low or elevated blood sugars/glucoses placed 3 of 8 (Residents #14, 15 and 16) sampled residents identified by the facility as being insulin dependent in conditions that are, or are likely to be serious and immediate threat to their health. The failure to administer insulin in a timely manner in relation to a meal and the failure to administer the correct dosage of insulin placed Residents #4 and #14 in conditions that are, or likely to be in a serious and immediate threat to their health. The insulin dependent diabetics have the high likelihood of having hypoglycemia and hyperglycemia episodes by receiving the wrong insulin or the wrong insulin doses. A conference was held in the conference room on 11/10/09 at 4:45 PM, at which time the Administrator and Director of Nursing (DON) were informed of the findings that placed the diabetic residents in Immediate Jeopardy (IJ). The IJ effective date is 11/10/09, and is ongoing until the IJ is removed. The findings included: 1. The administrative staff failed to ensure physicians were notified of low and/or elevated blood glucose (BG) levels. The facility failed to notify the physician of a BG as high as 541 for Resident #14 on 3/15/09 at 8:00 PM. The facility failed to notify the physician of a low BG of 40 on Resident #15 on 8/4/09 and a low BG of 45 on	F 490	The Director of Nursing with supervision and input from Nurse Consultant ensured that the following corrective measures were taken and that the Administrator was informed and approved: The physicians for Residents # 14, # 15, and # 16 were notified of the blood glucose results for October and November on 11/20/09 by the Nurse consultant, RN. On 11/24/09, the NC, RN and the DON verified with the physician for Resident # 14 that he (the physician) was aware on 11/20/09 of blood sugars on Resident # 14 for months of March, August, June, September 2009, the HGB AIC results of June and September 2009, the wrong insulin administered and no MD SSI order for range 401-450 during August and September. On 11/24/09 the NC, RN and the DON verified with the Physician for Resident # 15 that he(the physician) was aware on 11/20/09 for blood sugars on Resident # 15	

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F 490	<p>Continued From page 79</p> <p>9/28/09. The facility failed to notify the physician of a low BG of 49 on Resident #16 on 11/8/09. Refer to F157.</p> <p>2. The administrative staff failed to ensure that residents were free of significant medication errors. The nursing staff failed to administer insulin within the proper time frame before a meal, administer the correct amount of insulin according to the sliding scale and/or failed to obtain orders for insulin administration which placed diabetic residents in a serious and immediate threat to their health. The insulin dependent diabetics have the high likelihood of having hypoglycemia and hyperglycemia episodes by receiving the wrong insulin or the wrong insulin doses which resulted in immediate jeopardy (IJ) for 2 of 7 (Residents #4 and 14) sampled residents receiving insulin. Refer to F333.</p> <p>3. The administrative staff failed to ensure the Consulting Pharmacist monitored, reviewed and identified concerns with medication administration, inserviced nurses, ensure medications were available and participated in the Quality Assurance meetings. Refer to F428.</p> <p>4. The facility's administration including the Administrator and the Director of Nursing (DON) failed to effectively and efficiently ensure that all residents were maintained at their highest practicable well-being. The administrative staff failed to ensure that the facility identified, monitored and followed-up on quality of care issues such as notifying the physician of high and low blood glucose (BG) levels, failed to ensure there were no significant medication errors, failed to ensure the pharmacy consultant monitored</p>	F 490	<p>for months of August and September 2009. Residents #4 and #14 are now having their insulin administered within the proper time frame before meals, correct amount, the correct insulin ordered, and as per current physician orders. Physicians for resident #4 and #14 were contacted for clarification orders for correct timing, correct insulin, and correct amount on 11/10 and 11/11/09. The residents were reassessed and physicians notified by the DON and the NC,RN on 11/10/09 and 11/11/09. Residents # 11, # 14 #15, and #18 and Random residents #1,#3, #4, and # 5 are receiving medication correctly and consistently, within the proper time frame, and according to current physicians orders as of 11/13/09. This was verified by the DON thru observation and record review. The pharmacy consultant reviewed Residents # 11,#14,# #15, and 18 and Random Residents 1,3,4, and 5 medication regimen on 11/13/09 and</p>	
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F 490	<p>Continued From page 80</p> <p>medication administration and the availability of medications and failed to ensure the Medical Director participated in the Quality Assurance process.</p> <p>During an interview in the conference room on 11/11/09 at 8:35 AM, the Consultant Pharmacist was asked how long he had been consulting with this facility, how often did he come to the facility and what was he responsible for. The Consultant Pharmacist (CP) stated, "I have been coming here pretty close to a year... I am here once a month... I do general medication reviews..." The surveyor asked the CP if he had done any inservices with the nursing staff. The CP stated, "I have not done any recently due to the turn over [with staff]..." The surveyor asked the CP what charts did he review, what did he look at and how often. The CP stated, "Monthly... I look at every chart in the building... chart reviews, I look at allergies, labs and anything to do with medications..." The CP was asked if he had found any problems with insulins. The CP stated, "No, I have not..." The CP was asked if he had found in his review any holes/blanks in the MAR. The CP stated, "One hole is too many... I just don't know how to enforce making the nurses scared to leave holes..." The CP was asked if he had attended the facility's Quality Assurance (QA) meetings. The CP stated, "They have not requested me at QA." The CP was asked if he reviewed the resident's orders and recertification orders. The CP stated, "I do not review every single order... No... There are some [orders] that do not get documented accurately." The CP was asked if he was aware of any serious problems with the recertification orders. The CP stated, "Well, they have a serious problem with staffing... Every month it is different nurses..." The CP was asked</p>	F 490	<p>recommendations were made and sent to the physician on 11/13/09. The Administrator re-educated the pharmacy consultant on 11/12/09 regarding the expectations of a monthly medication regimen review for all residents and identification and reporting of medications being administered correctly and consistently, timing of insulin in relation to meals, the correct dosage of insulin, the correct insulin, ranges of SSI and physicians orders for medication.</p> <p>The Medical Director has participated in a QA meeting and has held an in-service for the nurses.</p> <p>2. The Director of Nursing with supervision and input from the Nurse Consultant ensured that the following was done to identify others with the potential to be affected, corrective measures were taken and that the Administrator was informed and approved: Other resident's with the</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445339	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/11/2009
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NAME OF PROVIDER OR SUPPLIER BAILEY PARK CLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 MITCHELL STREET HUMBOLDT, TN 38343
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F 490	<p>Continued From page 81</p> <p>if he felt there was a problem at this facility. The CP stated, "Absolutely... Staffing has been a huge issue..."</p> <p>Review of the Consultant Pharmacist Review sheet for 3/20/09 through 10/23/09 had no documentation of the identified concerns with insulin administration for Resident #14, yet the pharmacist stated he reviewed every chart. Refer to F333.</p> <p>During an interview in the conference room on 11/11/09 at 9:10 AM, Nurse #8 was asked if the facility had provided any inservices regarding insulins and how insulins should be administered, "None before you [surveyors] got here... Now, they [the facility] wants to put it [accuchecks and morning insulin administration] on us [the day shift nurses]... This morning [11/11/09 they changed it to give [morning insulins] at 7 AM... They won't listen to me... They have just made these changes to impress you."</p> <p>The surveyors attempted to contact the Medical Director on 11/11/09. The Medical Director returned the call to the state office on 11/12/09 at 10:15 AM. The Medical Director (MD) confirmed that he was not aware of any problems with blood sugars until 11/11/09 and had not been invited to a Quality Assurance (QA) meeting in 4 to 5 months due to the recent changes in administration. When the MD was asked about attending and participating in QA, he stated, "I think before quarterly [when he attended QA], but changes with the Administrator and maybe the Nursing Director, I have not... Whenever they call me I come right away. They have not called me in four or five months. I think it is due to rapid change over with staff... There is this rapid in and</p>	F 490	<p>potential to be affected were identified by a review of the blood glucoses for the past month of diabetic residents by Director of Nursing and the Nurse Consultant on 11/11/09. Findings from the review were lack of notification parameters and inadequate insulin orders. The physicians were notified as needed by the DON and/or NC for new orders. This review included all diabetics. The primary nurse for the resident will be responsible for notification of the physician going forward.</p> <p>Other residents with the diagnosis of diabetes have the potential to be affected and the diagnosis was used to identify which resident. The residents identified by the DON and NC, RN had physician orders clarified for insulin administration times and amounts, ranges of insulin, and correct insulin on 11/10/09 and 11/11/09.</p> <p>The pharmacy consultant completed a medication regimen review for all residents on 11/13/09 and recommendations were made</p>	
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F 490	<p>Continued From page 81</p> <p>if he felt there was a problem at this facility. The CP stated, "Absolutely... Staffing has been a huge issue..."</p> <p>Review of the Consultant Pharmacist Review sheet for 3/20/09 through 10/23/09 had no documentation of the identified concerns with insulin administration for Resident #14, yet the pharmacist stated he reviewed every chart. Refer to F333.</p> <p>During an interview in the conference room on 11/11/09 at 9:10 AM, Nurse #8 was asked if the facility had provided any inservices regarding insulins and how insulins should be administered, "None before you [surveyors] got here... Now, they [the facility] wants to put it [accuchecks and morning insulin administration] on us [the day shift nurses]... This morning [11/11/09 they changed it to give [morning insulins] at 7 AM... They won't listen to me... They have just made these changes to impress you."</p> <p>The surveyors attempted to contact the Medical Director on 11/11/09. The Medical Director returned the call to the state office on 11/12/09 at 10:15 AM. The Medical Director (MD) confirmed that he was not aware of any problems with blood sugars until 11/11/09 and had not been invited to a Quality Assurance (QA) meeting in 4 to 5 months due to the recent changes in administration. When the MD was asked about attending and participating in QA, he stated, "I think before quarterly [when he attended QA], but changes with the Administrator and maybe the Nursing Director, I have not... Whenever they call me I come right away. They have not called me in four or five months. I think it is due to rapid change over with staff... There is this rapid in and</p>	F 490	<p>and sent to physicians. Correct insulin type was included where applicable. A medication/ MAR reconciliation to ensure meds available was done by the DON and NC, RN on 11/19/09 and meds ordered if needed.</p> <p>3. The facility administrator was re-educated by the Regional Director on 11/11/09 regarding the expectations and responsibilities of the administrator's role in effectively and efficiently administering the facility. The DON was re-educated by the Nurse Consultant on 11/11/09 regarding the expectations and responsibilities of the DON role in effectively and efficiently administering the facility. The Director of Nursing with supervision and input from the Nurse Consultant ensured that the following measures and or systematic changes were made so that previous practices do not recur. The Administrator was informed and approved:</p>

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F 490	<p>Continued From page 81</p> <p>if he felt there was a problem at this facility. The CP stated, "Absolutely... Staffing has been a huge issue..."</p> <p>Review of the Consultant Pharmacist Review sheet for 3/20/09 through 10/23/09 had no documentation of the identified concerns with insulin administration for Resident #14, yet the pharmacist stated he reviewed every chart. Refer to F333.</p> <p>During an interview in the conference room on 11/11/09 at 9:10 AM, Nurse #8 was asked if the facility had provided any inservices regarding insulins and how insulins should be administered, "None before you [surveyors] got here... Now, they [the facility] wants to put it [accuchecks and morning insulin administration] on us [the day shift nurses]... This morning [11/11/09 they changed it to give [morning insulins] at 7 AM... They won't listen to me... They have just made these changes to impress you."</p> <p>The surveyors attempted to contact the Medical Director on 11/11/09. The Medical Director returned the call to the state office on 11/12/09 at 10:15 AM. The Medical Director (MD) confirmed that he was not aware of any problems with blood sugars until 11/11/09 and had not been invited to a Quality Assurance (QA) meeting in 4 to 5 months due to the recent changes in administration. When the MD was asked about attending and participating in QA, he stated, "I think before quarterly [when he attended QA], but changes with the Administrator and maybe the Nursing Director, I have not... Whenever they call me I come right away. They have not called me in four or five months. I think it is due to rapid change over with staff... There is this rapid in and</p>	F 490	<p>Director of Nursing or Nurse Consultant will review the audits daily for completeness for 2 weeks then weekly for 2 weeks then monthly for the next 12 months (Start date 11/13/09). The Director of Nursing or the RN supervisor will verify the accuracy of one audit a week for 2 weeks, the one per month for 2 months, and then quarterly for the next 12 months (Start date 11/13/09)</p> <p>The Director of Nursing and the Nurse Consultant are doing a daily audit of actual insulin administration in relation to meal times and the results recorded. This will be done daily for 2 weeks (Start date 11/10/09) and then weekly for 2 weeks and then quarterly for the next 12 months. The results of the audits will be reported to the QA committee weekly for 4 weeks and then quarterly for the next 12 months. The QA committee, comprised of the Administrator, the Director of Nursing, the Medical Director, Dietician /food service manager, the Pharmacy Consultant, the Social Services director, the Activity director,</p>	
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NAME OF PROVIDER OR SUPPLIER BAILEY PARK CLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 MITCHELL STREET HUMBOLDT, TN 38343
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F 490	<p>Continued From page 81</p> <p>if he felt there was a problem at this facility. The CP stated, "Absolutely... Staffing has been a huge issue..."</p> <p>Review of the Consultant Pharmacist Review sheet for 3/20/09 through 10/23/09 had no documentation of the identified concerns with insulin administration for Resident #14, yet the pharmacist stated he reviewed every chart. Refer to F333.</p> <p>During an interview in the conference room on 11/11/09 at 9:10 AM, Nurse #8 was asked if the facility had provided any inservices regarding insulins and how insulins should be administered. "None before you [surveyors] got here... Now, they [the facility] wants to put it [accuchecks and morning insulin administration] on us [the day shift nurses]... This morning [11/11/09 they changed it to give [morning insulins] at 7 AM... They won't listen to me... They have just made these changes to impress you."</p> <p>The surveyors attempted to contact the Medical Director on 11/11/09. The Medical Director returned the call to the state office on 11/12/09 at 10:15 AM. The Medical Director (MD) confirmed that he was not aware of any problems with blood sugars until 11/11/09 and had not been invited to a Quality Assurance (QA) meeting in 4 to 5 months due to the recent changes in administration. When the MD was asked about attending and participating in QA, he stated, "I think before quarterly [when he attended QA], but changes with the Administrator and maybe the Nursing Director, I have not... Whenever they call me I come right away. They have not called me in four or five months. I think it is due to rapid change over with staff... There is this rapid in and</p>	F 490	<p>the environmental services director, the MDS coordinator, and others as appointed by the administrator, will make any needed changes to the plan . The Pharmacy consultant will create a written report of findings on each visit. The ADM will complete the Quarterly Report quarterly to verify the Pharmacy consultant performance. The Director of Nursing will review the Pharmacy report for accuracy and completeness on a monthly basis and the Med Availability Audit weekly and report any findings to the QA committee weekly for 4 weeks and then quarterly . The QA committee, comprised of the Administrator, the Director of Nursing, the Medical Director, Dietician /food service manager, the Pharmacy Consultant, the Social Services director, the Activity director, the environmental services director, the MDS coordinator, and others as appointed by the administrator, will make any needed changes to the plan . The functioning of the QA committee and the facility's progress on the action plans</p>	
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F 490	<p>Continued From page 81</p> <p>If he felt there was a problem at this facility. The CP stated, "Absolutely... Staffing has been a huge issue..."</p> <p>Review of the Consultant Pharmacist Review sheet for 3/20/09 through 10/23/09 had no documentation of the identified concerns with insulin administration for Resident #14, yet the pharmacist stated he reviewed every chart. Refer to F333.</p> <p>During an interview in the conference room on 11/11/09 at 9:10 AM, Nurse #8 was asked if the facility had provided any inservices regarding insulins and how insulins should be administered, "None before you [surveyors] got here... Now, they [the facility] wants to put it [accuchecks and morning insulin administration] on us [the day shift nurses]... This morning [11/11/09 they changed it to give [morning insulins] at 7 AM... They won't listen to me... They have just made these changes to impress you."</p> <p>The surveyors attempted to contact the Medical Director on 11/11/09. The Medical Director returned the call to the state office on 11/12/09 at 10:15 AM. The Medical Director (MD) confirmed that he was not aware of any problems with blood sugars until 11/11/09 and had not been invited to a Quality Assurance (QA) meeting in 4 to 5 months due to the recent changes in administration. When the MD was asked about attending and participating in QA, he stated, "I think before quarterly [when he attended QA], but changes with the Administrator and maybe the Nursing Director, I have not... Whenever they call me I come right away. They have not called me in four or five months. I think it is due to rapid change over with staff... There is this rapid in and</p>	F 490	<p>will be reviewed weekly by the Regional Director and the nurse consultant for 4 weeks and then monthly for 3 months and then quarterly for the next 12 months.</p>	
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F 490	Continued From page 82	F 490			
F 514	out of nurses..." Refer to F520.	F 514			
SS=J	483.75(l)(1) CLINICAL RECORDS				
	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.		F514		11-20-09
	The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.		1. Resident #14 now has documentation of accuchecks and correct insulin as ordered, has sliding scale with ranges with no blanks in the ranges, and notification parameters in place verified by the DON 11/10/09.		
	This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review and interview, it was determined the facility failed to maintain complete and accurate medical records as evidenced by blanks on the Medication Administration Record (MAR) and blood glucose (BG) flow sheets, failure of the physician to set parameters for sliding scale insulin (SSI) and/or the nurses failed to notify the physician of no parameters for SSI for BG range from 401 to (-) 450 and/or 401- 499 for 3 of 8 (Residents #4, 14, and 15) sampled residents that the facility had identified and documented as being insulin dependent. The insulin dependent diabetics had the high likelihood of having hypo/hyperglycemia episodes by receiving the wrong insulin or the wrong insulin doses. A conference was held in the conference room on 11/10/09 at 4:45 PM, at which time the Administrator and Director of Nursing (DON) were informed of the findings that are, or are likely to		Resident #4 now has documentation of accuchecks and correct insulin as ordered, has sliding scale with ranges with no blanks in the ranges and notification parameters in place verified by the DON on 11/10/09.		
			Resident #15 now has documentation of accuchecks and correct insulin as ordered, has sliding scale with ranges with no blanks in the ranges and notification parameters in place verified by the DON on 11/10/09.		

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F 514	<p>Continued From page 83</p> <p>place diabetic residents in serious and immediate threat to their health which resulted in an immediate Jeopardy (IJ). The IJ effective date is 11/10/09, and is ongoing until the IJ is removed.</p> <p>The findings included:</p> <p>1. Review of the facility's "Changes in a Resident's Condition or Status" policy documented, "...It is the policy of this facility...Procedure 1. Nursing services shall be responsible for notifying the resident's attending physician when ...d. There is a need to alter the resident's treatment significantly... 4. All notifications must be made as soon as practical, but in no case shall such notification exceed twenty-four (24) hours. 5. All changes in the resident's medical condition must be properly recorded in the resident's medical record..."</p> <p>Review of the facility's "Diabetic Therapeutic Protocol" policy documented, "The physician must approve the use of the Diabetic Therapeutic Protocol for each of her/his use and write a corresponding order in the medical record. Nurses will be informed of this protocol upon hire and regularly thereafter. Hypoglycemia Protocol If the resident is asymptomatic, alert, and the finger stick blood glucose is less than 50 (or as indicated by the physician)...4. Notify the physician. The physician is notified even if the resident improves...Hyperglycemia Protocol If the resident is alert, asymptomatic, and a finger stick blood glucose is greater than 450 (or as indicated by the physician): 1. If sliding scale insulin is ordered, give the ordered dose. 2. Recheck the finger stick blood glucose in 10 min [minutes]. If no improvement in the finger stick glucose, notify the physician. 3. If no sliding scale insulin is</p>	F 514	<p>2. Other residents with the potential to be affected were identified by a review of the residents with the diagnosis of diabetes conducted by the DON and NC from 11/10 through 11/19/09 that included a review of documentation of accuchecks, correct insulin as ordered, SSI with ranges with no blanks in the ranges, and notification parameters. This included completeness of documentation on the MAR.</p> <p>3. Nurses were inserviced on regarding completing the documentation of medication and treatments given on 11/10/09 by the DON, NC and ADM.</p> <p>Nurses not in serviced on this date will be in serviced prior to returning to duty . No agency nurses are utilized at this time. In-service will be conducted upon hire and annually thereafter. Agency nurses will be in serviced prior to working. These in-services will be conducted by the Director of Nursing or the RN supervisor.</p>	
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F 514	<p>Continued From page 84 ordered, notify the physician."</p> <p>2. Medical record review for Resident #14 documented an admission date of 2/26/09 with diagnoses of Mood Disorder, Benign Prostate Hypertrophy, Suicidal Ideation, Diabetic Retinopathy, Gastroesophageal Reflux Disease, Hypertension and Diabetes Mellitus. Review of Resident #14's March 2009 Medication Administration Record (MAR) documented "...NOVOLOG ...GIVE 15 UNITS DAILY AT 7am... NOVOLOG ...GIVE 15 UNITS SUBQ [subcutaneous] AT 1130A... NOVOLOG ...GIVE 15 UNITS SUBQ DAILY AT 4PM... LANTUS ...50 UNITS SUBQ DAILY AT HS..." There was an entry written in on the March 2009 MAR for "...Accu [check] 6AM..." There was no documentation that the BG was checked at 6:00 AM on 3/1/09 and 3/4/09. The 7:00 AM dose of Novolog was left blank, and not initialed as given for 3/1/09 through 3/4/09. The 11:30 AM Novolog dose was left blank, and not initialed as given for 3/4/09. The 4:00 PM dose of Novolog dose was left blank as not given.</p> <p>Review of Resident #14's BG flow sheets for 3/7/09 through 3/21/09 documented 60 opportunities for the BG to be checked. There were 3 opportunities with no documentation that the BG had been obtained as ordered.</p> <p>A telephone order obtained on 3/11/09 documented "...Blood glucose Q2 [every two hours] X [times] 24 [hours]..." There was no documentation that the Q2 hour BS were obtained after 10:30 PM on 3/11/09.</p> <p>Review of the March 2009 patient record log documented 3/13/09 at 6:00 AM - BG = no</p>	F 514	<p>A Med Pass Shift Change Daily Audit tool was created on 11/12/09 by the DON.</p> <p>4. The nurses will complete the Med Pass Shift Change Daily audit every shift ongoing. The Director of Nursing will review the results of the audits 5 days a week for 4 weeks and then weekly for 4 weeks and then monthly ongoing and will report the results to the QA committee weekly for 4 weeks and then monthly for 3 months and then quarterly. The QA committee, comprised of the Administrator, the Director of Nursing, the Medical Director, Dietician /food service manager, the Pharmacy Consultant, the Social Services director, the Activity director, the environmental services director, the MDS coordinator, and others as appointed by the administrator, will make any needed changes to the plan .</p>	

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F 514	<p>Continued From page 85 documentation of a BG being obtained.</p> <p>Review of a telephone order dated 3/21/09 for Resident #14 documented "...NO [new order] for Novolog sliding scale [SSI] 150- [to] 200 [administer] 4U, 201-250 6U...251-300 8U, 301-350 10U, 351-400 12U, 450 & ^ [above] 14 units & [and] above 450 monitor q 4 [hours]..." There was no order for an insulin dose for a BG between 401 and 449. There was no documentation that the physician was notified that there were no orders for sliding scale (SS) insulin for a BG range of 401-449 nor was a physician order obtained for SS Insulin for BG levels within the range of 401-449.</p> <p>Review of Resident #14's March 2009 Medication Administration Record (MAR) documented "...NOVOLOG ...GIVE 15 UNITS DAILY AT 7am... NOVOLOG ...GIVE 15 UNITS SUBQ [subcutaneous] AT 1130A... NOVOLOG ...GIVE 15 UNITS SUBQ DAILY AT 4PM... LANTUS ...50 UNITS SUBQ DAILY AT HS..." Documentation of "ACCUCHECK AC AND HS" listed the times of "6AM ...11AM ...4PM ...9PM..."</p> <p>There was a separate hand written entry on the March 2009 MAR for "...Accu [check] 6AM..." There was no documentation on the March MAR that the BG was checked at 6:00 AM on 3/1/09 and 3/4/09. (The BG flow sheet documented the 3/1/09 BG was 212 but had no documentation for BG on 3/4/09 at 6 AM.) There was a discrepancy between the MAR and the BG flow sheet.</p> <p>On the March 2009 MAR 7:00 AM dose of Novolog 15 Units was left blank, and not initialed as given for 3/3/09 and 3/4/09.</p>	F 514		

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F 514	<p>Continued From page 86</p> <p>On the March 2009 MAR the 11:30 AM Novolog dose was left blank, and not initialed as given for 3/4/09. The 4:00 PM Novolog dose was left blank as not given.</p> <p>Review of Resident #14's BG flow sheets for "March 09" documented no BG levels for 3/4 and 3/5/09. The BG flow sheets for 3/7/09 through 3/21/09 documented 60 opportunities for the BG to be checked. There were 3 opportunities with no documentation that the BG had been obtained as ordered (the spaces were blank). Resident #14's BG ranged from a low of 54 on 3/8/09 at 9:00 PM to a high of 541 on 3/15/09 at 8:00 PM.</p> <p>An undated telephone order signed by Registered Nurse #11 at 8:30 AM and signed by the physician on 4/13/09 documented "...D5W [Dextrose 5 percent water] @ [at] 70 cc [cubic centimeter] / [per] hr [hour] until BG over 300 then D/C... Blood glucose Q2 [every two hours] X [times] 24 [hours]... Hold all insulin for now... [change] Lantus to Levimir 20U [units] @ HS & 10 U in am..."</p> <p>In review of this telephone order signed by the physician on 4/13/09, the reviewer would have no knowledge that the telephone order was given on 3/11/09 until review of the nurses notes of 3/11/09 at 7:20 AM that documented the nurse called the physician and "got orders ...IV started ...D5W @ 70 infusing..." and both telephone order and nurses note were signed by Registered Nurse #11.</p> <p>Review of the BG flow sheets revealed there was no documentation that the Q2 hour BS was obtained after 10:30 PM on 3/11/09.</p>	F 514		

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F 514	<p>Continued From page 87</p> <p>Review of Resident #14's March 2009 MAR revealed Levimir 10 U at 6 AM should have been given on 3/12/09, but the space is blank. Levimir 20 U at HS revealed a blank space for 3/30/09; and then documented given on 3/31/09. Levimir 20 U at HS should have been given from 3/11/09 through 3/15/09, but the spaces are blank for these dates.</p> <p>Review of the March 2009 MAR documented physician ordered (3/6/09) scheduled Novolog 12 U before breakfast, lunch & supper was not given on 3/12 to 13/09 as ordered and not given before breakfast on 3/14/09. A hand-written note documented the scheduled Novolog was "DC'd 3-21-09." The telephone order of 3/11/09 changing the long acting Lantus to Levimir did not address the shorter acting scheduled 12 U of Novolog before breakfast, lunch and supper. The new phone order on 3/21/09 for Novolog sliding scale insulin was not followed from 3/21/09 through 3/25/09 at 6 AM. Instead, the scheduled dose of Novolog 12 U was given from 3/21/09 from to 3/25/09.</p> <p>Review of a telephone order dated 3/21/09 for Resident #14 documented "...NO [new order] for Novolog sliding scale [SSI] 150- [to] 200 [administer] 4U, 201-250 6U...251-300 8U, 301-350 10U, 351-400 12U, 450 & ^ 14 units & above 450 monitor q 4 [hours]..." There was no order for an insulin dose for a BG between 401 and 449. The staff failed to follow the facility's diabetic therapeutic protocol of notifying the physician if no sliding scale insulin is ordered.</p> <p>Review of Resident #14's blood sugar flow sheet for 3/22/09 through 3/31/09 documented 40 opportunities for the BG to be checked. The blood</p>	F 514		
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F 514	<p>Continued From page 88</p> <p>sugar flow sheet revealed blank spaces as follows:</p> <p>a. 3/25/09 at 9:00 PM - BG = 262, Insulin given = blank space - no documentation of SSI given.</p> <p>b. 3/26/09 at 6:00 AM - BG was blank.</p> <p>c. 3/28/09 at 8:30 PM - BG was blank.</p> <p>d. 3/30/09 at 6:00 AM - BG = 259, Insulin given = blank space - no documentation of SSI given.</p> <p>Review of Resident #14's physician orders dated 8/1/09 documented "...LEVIMIR INSULIN 20u q am ... ACCUCHECK AC AND HS SS [sliding scale] NOVLOG INSULIN ... 150-200 4U ...201-250 6 U ...251-300 8U ...301-350 10U ...351-400 15 U ... [No physician order for Novolog sliding scale insulin for BG range of 401-450] ...451-14U AND MONITOR Q 4 HRS TIL [until] STABLE..." There was no physician order for Levimir Insulin 25 U HS that was hand written onto the August 2009 MAR. There was no documentation that the physician was notified that there were no orders for SS insulin for a BG range of 401-450 nor was a physician order obtained for SS Insulin for BG levels within the range of 401-450.</p> <p>Review of Resident #14's August 2009 BG flow sheets documented 124 opportunities for BG to be checked. There were 4 opportunities for BG to be checked with no documentation that a BG was obtained. The August 2009 BG flow sheets revealed the following:</p> <p>a. 8/5/09 at 4:30 - PM - BG = was 297 with no documentation that Novolog insulin administered.</p> <p>b. 8/6/09 at 8:00 PM - BG = blank no documentation the BS was obtained.</p> <p>c. 8/7/09 at 8:00 PM - BG = 231, Insulin given = Levimir no amount given.</p> <p>d. 8/10/09 at 8:00 PM - BG = blank no</p>	F 514		
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NAME OF PROVIDER OR SUPPLIER BAILEY PARK CLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2400 MITCHELL STREET HUMBOLDT, TN 38343	
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F 514	<p>Continued From page 89</p> <p>documentation the BS was obtained.</p> <p>e. 8/11/09 at 8:30 PM - BG = 231 Insulin given = Levimir no amount given.</p> <p>f. 8/14/09 at 4:00 PM - BG = 507 insulin given is blank.</p> <p>g. 8/22/09 at 9:00 AM - no BG obtained.</p> <p>h. 8/25/09 at 4:00 PM - BG = 247, Insulin given = There was a blank space with no documentation of Novolog sliding scale insulin given.</p> <p>i. 8/26/09 at 11:00 AM - no BG obtained.</p> <p>j. 8/29/09 at 4:00 PM - BG = 224, Insulin given = There was a blank space with no documentation of Novolog sliding scale insulin given.</p> <p>There was no documentation of Novolog sliding scale insulin administered per physician orders for (5 times) 8/2, 8/7, 8/11, 8/15, and 8/16/09.</p> <p>Review of Resident #14's recertification physician's orders dated 9/2/09 documented, "Levemir 25 Units Subcutaneous Every HS At 9 PM For Diabetes... Levimir Insulin 20 u Q AM... Accuchecks AC and HS SS Novolog Insulin 150-200=4u, 201-250=6u, 251-300=8u, 301-350=10u, 351-400=15u, 451-14u And Monitor Q [every] 4 HRS Til [until] Stable..."</p> <p>Review of Resident #14's September 2009 MAR revealed the following:</p> <p>a. 9/2/09 at 4:00 PM - BG = 241, insulin given is blank.</p> <p>b. 9/2/09 at 8:00 PM - BG = 208, insulin given is blank.</p> <p>c. 9/5/09 at 6:00 AM - BG = 167, insulin given is blank.</p> <p>d. 9/7/09 at 6:00 PM - BG = 165, insulin given is blank.</p> <p>e. 9/8/09 at 8:00 PM - BG = is blank.</p> <p>f. 9/12/09 at 6:00 AM - BG = 317, insulin given is blank.</p>	F 514		

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F 514	<p>Continued From page 90</p> <p>g. 9/12/09 at 8:00 PM - BG 264, insulin given is blank.</p> <p>h. 9/13/09 at 4:00 PM - BG = 289, insulin given is blank.</p> <p>i. 9/14/09 at 4:00 PM - BG = 307, insulin given is blank.</p> <p>j. 9/17/09 at 4:00 PM - BG = 269, insulin given is blank.</p> <p>k. 9/17/09 at 8:00 PM - BG = 176, insulin given is blank.</p> <p>l. 9/18/09 at 6:00 AM - BG = 201, insulin given is blank.</p> <p>m. 9/20/09 at 6:00 AM - BG = 215, insulin given is blank.</p> <p>Review of Resident #14's physician's orders dated 10/21/09 documented "...LEVIMIR INSULIN 20U Q AM..." and an order initiated 9/12/09 for "...ACCUCHECKS AC AND HS WITH SLIDING SCALE INSULIN NOVOLOG 0-149= [amount of insulin to be administered] 0 UNITS, 150-200=4 UNITS, 201-250=6 UNITS, 251-300=8 UNITS, 301-350=10 UNITS, 351-400=12 UNITS, 401 OR GREATER=14 UNITS AND MONITOR Q 4 HOURS UNTIL STABLE AND NOTIFY MD..."</p> <p>Review of Resident #14's October 2009 MAR revealed the following:</p> <p>a. 10/2/09 at 11:00 AM - BG = 214, insulin given is blank.</p> <p>b. 10/19/09 at 6:00 AM - BG = 150, insulin given is blank.</p> <p>c. 10/10/09 at 6:00 AM - BG = 150, insulin given is blank.</p> <p>d. 10/11/09 at 11:00 AM - BG 267, insulin given is blank.</p> <p>e. 10/15/09 at 11:00 AM - BG = 312, insulin given is blank.</p> <p>f. 10/20/09 at 4:00 PM - BG = 300, insulin given is</p>	F 514		

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F 514	<p>Continued From page 91</p> <p>blank.</p> <p>g. 10/21/09 at 9:00 PM - BG = 178, insulin given is blank.</p> <p>h. 10/29/09 at 11:00 AM - BG = 215, insulin given is blank.</p> <p>Review of Resident #14's physician's orders dated 11/2/09 documented the same insulin orders as for October 2009. There were 3 times 11/2/09 through 11/9/09 that SSI was left blank as follows: 11/3/09 at 11:00 AM, 11/6/09 at 6:00 AM and 11/9/09 at 11:00 AM.</p> <p>3. Medical record review for Resident #4 documented an admission date of 2/26/09 with a readmission date of 10/1/09 with current diagnoses of Diabetes, Aphasia, Hypertension, Convulsions, Stroke with Hemiparesis and Dementia. Review of Resident #4's August 2009 physician's order documented, "NOVOLIN R PER SLIDING SCALE AC AND HS[bedtime] 151-200 =3U, 201-250 =5U, 251-300 = 7U, 301-350 =9U 351-400 = 11U Over 400 CALL MD."</p> <p>Review of Resident #4's August 2009 MAR and the BG flow sheet revealed the following:</p> <p>a. 8/6/09 at 8:00 PM - BG 153, insulin given is blank.</p> <p>b. 8/26/09 at 11:00 AM - BG 211, insulin given is blank.</p> <p>c. 8/26/09 at 4:00 PM - BG 221, insulin given is blank.</p> <p>d. 8/29/09 at 6:00 AM - BG 167, insulin given is blank.</p> <p>Review of Resident #4's physician's orders dated 9/11/09 documented, "...OBTAIN ACCUCHECKS Q AM AT 6 AM WITH SSI NOVOLIN R ...151-200 =3U..."</p>	F 514			

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F 514	<p>Continued From page 92</p> <p>Review of Resident #4's September 2009 BG flow sheets for 9/1/09 through 9/30/09 documented 30 opportunities for the BG to be checked at 6:00 AM. The BG on 9/18/09 at 6:00 AM was 201 the amount of insulin given was blank.</p> <p>During an interview in the state office on 11/12/09 at 4:40 PM, the Attending Physician for Resident #4 verified that he was not aware of any problems with insulin regarding his residents in recent times.</p> <p>4. Medical record review for Resident #15 documented an admission date of 7/10/09 with diagnoses of Diabetes, Hypertension, Tobacco Use Disorder and Below knee Amputation. Review of a physician's order dated 8/12/09 and 9/1/09 documented, "...ACCU CHECK AC [before meals] /HS W [WITH] NOVOLIN R SS [SLIDING SCALE] COVERAGE 0-60 = 4oz [ounces] OJ [orange juice] 61-150 = NO COVERAGE, 151-200 = 2U, 201-250 = 4U, 251-300 = 6U, GREATER THAN 300 = 8U..."</p> <p>Review of Resident #15's BG flow sheets for 8/1/09 through 8/31/09 documented 31 opportunities for the BG to be checked at bedtime (HS). There were 25 opportunities with no documentation on the MAR or BG flow sheets that the HS BG was obtained.</p> <p>Review of Resident #15's September BG flow sheets for 9/1/09 through 9/30/09 documented 30 opportunities for the BG to be checked at HS. There were 25 opportunities with no documentation that the HS BG had been obtained as ordered. Resident #15's BG ranged from a</p>	F 514		
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F 514	<p>Continued From page 93</p> <p>high of 346 on 9/3/09 at 4:00 PM to a low of 45 on 9/28/09 at 6:00 AM.</p> <p>Review of Resident #15's October BG flow sheet from 10/1/09 through 10/31/09 documented 22 opportunities for the BG to be checked at HS. There were 20 opportunities with no documentation on the MAR or BG flow sheet that the HS BG's had been done as ordered. Resident #15's BG ranged from a high of 200 on 10/4/09 at 4:00 PM to a low of 49 on 10/19/09 at 6:00 AM.</p> <p>During an interview in the state office on 11/12/09 at 4:40 PM, the attending Physician for Residents #15 verified that he was not aware of any problems with insulin regarding his residents.</p> <p>5. During an interview in the conference room on 11/11/09 at 8:35 AM, the Consultant Pharmacist was asked how long he had been consulting with this facility, how often did he come to the facility and what was he responsible for. The Consultant Pharmacist (CP) stated, "I have been coming here pretty close to a year... I am here once a month... I do general medication reviews..." The surveyor asked the CP if he had done any inservices with the nursing staff. The CP stated, "I have not done any recently due to the turn over [with staff]..." The surveyor asked the CP what charts did he review, what did he look at and how often. The CP stated, "Monthly...I look at every chart in the building...chart reviews, I look at allergies, labs and anything to do with medications..." The CP was asked if he had found any problems with insulins. The CP stated, "No, I have not... Me and [named the DON] did discuss the timing of insulins... the [hemoglobin] A1Cs [laboratory test that measures the average of the blood glucose levels over a three month period]</p>	F 514		
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F 514	Continued From page 94 have been good..." The CP was asked if he had found in his review any holes/blanks in the MAR. The CP stated, "One hole is too many... I just don't know how to enforce making the nurses scared to leave holes..." The CP was asked if he had attended the facility's Quality Assurance (QA) meetings. The CP stated, "They have not requested me at QA." The CP was asked if he reviewed the resident's orders and recertification orders. The CP stated, "I do not review every single order... No... There are some [orders] that do not get documented accurately." The CP was	F 514		
F 520 SS=J	asked if he was aware of any serious problems with the recertification orders. The CP stated, "Well, they have a serious problem with staffing... Every month it is different nurses..." The CP was asked if he felt there was a problem at this facility. The CP stated, "Absolutely... Staffing has been a huge issue..." 483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE 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	F 520	F520 1. The Quality Assurance Committee met on 11/13/09 and formulated action plans for the following processes: Notifying the physician of blood glucoses Insulin administration and diabetes management Pharmacy Services and availability of medication Medication Errors Quality Assessment and Assurance	11/17/09

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F 520	<p>Continued From page 95</p> <p>compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, "Pharmacy Services Agreement Terms and Conditions", medical record review, observations and interviews, it was determined the facility's administrative staff failed to identify and address quality of care issues such as notifying the physician of high and low blood glucose (BG) levels, failed to ensure that there were no significant medication errors, the pharmacy consultant failed to monitor, review and identify medication administration concerns to bring forth to the Quality Assurance Meetings and the Medical Director failed to participate in the Quality Assurance (QA) process. The failure of the administrative staff to identify and address these areas of concern to QA resulted in conditions that are, or are likely to place diabetic residents in a serious and immediate threat to their health. The insulin dependent diabetics have the high likely hood of having hypoglycemia and hyperglycemia episodes by receiving the wrong insulin or the wrong insulin doses. A conference was held in the conference room on 11/10/09 at 4:45 PM, at which time the Administrator and Director of Nursing (DON) were informed of the findings that placed the diabetic residents in Immediate Jeopardy.</p> <p>The findings included:</p>	F 520	<p>2. All residents have the potential to be affected</p> <p>3. The Quality Assurance Committee was in serviced on 11/17/09 regarding the requirements and functioning of a Quality Assurance program by the regional nurse. The in-service included identifying issues with respect to which quality assessment and assurance activities are necessary and developing and implementing plans of action to correct identified quality deficiencies. Systems were put into place to monitor change in condition, insulin administration, diabetes management, availability of medication, medication errors, quality assurance and pharmacy services.</p> <p>4. The functioning of the QA committee and the facility's progress on the action plans will be reviewed weekly by the Regional director and the nurse consultant for 4 weeks and then periodically thereafter.</p>	

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F 520	Continued From page 96 The administrative staff failed to ensure physicians were notified of low and/or elevated blood glucose (BG) levels. The facility failed to notify the physician of a BG as high as 541 for Resident #14 on 3/15/09 at 8:00 PM. The facility failed to notify the physician of a low BG of 40 on Resident #15 on 8/4/09 and a low BG of 45 on 9/28/09. The facility failed to notify the physician of a low BG of 49 on Resident #16 on 11/8/09. Refer to F157.	F 520		
	Review of the facility's "Pharmacy Services Agreement Terms and Conditions" documented, "1. Consulting Services...provides ...the following services at the Facility: (a) Once each month, consult with the Facility's staff as to each resident's drug regimen and provide a written report of concerns of inappropriate utilization patterns (if any) to the Facility's administrator, Director of Nursing Services or the resident's physician, as appropriate. (b) Consult with the Facility's staff as to its creation and maintenance of its Pharmacy Policy and Procedure Manual, including (without limitation) its creation and implementation of policies and procedures in respect of the distribution, control and use of prescription drugs in the Facility... (d) Once each month, observe a medication pass from the Facility to a patient, and note concerns related to quality assurance (if any) to the Facility's Administrator... (f) Using its pharmacy staff, coordinate and conduct two educational programs on pharmacy issues (each one-hour long) for the Facility's staff. (g) Once each month, attend a meeting with the Administrator and Director of Nursing at each Facility to discuss Pharmacy issues. (h) On Facility's request (but not more than once per calendar quarter), serve (in an advisory role) one the Facility's Quality Assurance			

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F 520	<p>Continued From page 97 and Assessment Committee..."</p> <p>During an interview in the conference room on 11/11/09 at 8:35 AM, the Consultant Pharmacist (CP) was asked if he had attended the facility's Quality Assurance (QA) meetings. The CP stated, "They have not requested me at QA."</p> <p>The pharmacy consultant failed to observe administration of medications with the nursing staff or to conduct inservice training for the nursing staff to ensure a medication error rate was less than five percent (%). Five (5) of 7 nurses (Nurses #1, 3, 4, 5 and 7) made 11 errors out of 43 opportunities for error which resulted in a medication error rate of 25.58%. Medication errors were made on all three shifts..</p> <p>The pharmacy consultant failed to observe administration of medications, failed to review medication administration records, failed to review blood sugar flow sheets for completeness, failed to ensure the accuracy of administration of sliding scale insulins and failed to review the accuracy of recertification orders. The pharmacy consultant failed to ensure nursing staff administered insulin within the proper time frame before a meal, administer the correct amount of insulin according to the sliding scale and/or failed to obtain orders for insulin that was administered resulted in conditions that are, or are likely to place diabetic residents in a serious and immediate threat to their health. The insulin dependent diabetics have the high likely hood of having hypoglycemia and hyperglycemia episodes by receiving the wrong insulin or the wrong insulin doses for 2 of 8 (Residents #4 and 14) sampled diabetic residents. Refer to F332, F333 and F428.</p>	F 520		

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F 520	<p>Continued From page 98</p> <p>During an interview in the conference room on 11/10/09 at 12:00 PM, the Administrator was asked if the facility conducted Quality Assurance meetings. The Administrator stated that they have monthly and quarterly meetings. The Administrator further stated that the Medical Director was on the committee. The Administrator was asked to provide proof that the Medical Director had attended the Quality Assurance meetings at least quarterly. The Administrator provided a sign-in sheet from July 2009. The Administrator stated that she could not find any proof that the Medical Director had attended any QA meetings since July 2009.</p> <p>The surveyors attempted to contact the Medical Director on 11/11/09. The Medical Director returned the call to the state office on 11/12/09 at 10:15 AM. The Medical Director was asked if he is involved with the Quality Assurance meetings. The Medical Director stated, "...changes with administration...whenever they call me I come... they haven't called me in 4 or 5 months..."</p>	F 520		