

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155392	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/19/2012
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NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT KENDALLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1433 S MAIN ST KENDALLVILLE, IN 46755
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F0000	<p>This visit was for the Investigation of Complaints IN00106240 and IN00106364.</p> <p>Complaint IN00106240 - Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F309, F323, F354, and F425.</p> <p>Complaint IN00106364 -Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F309, F323, and F354.</p> <p>Survey dates: April 17, 18, 19, 2012</p> <p>Facility number: 000402 Provider number: 155392 AIM number: 100288120</p> <p>Survey team: Ann Armey, RN, TC Ellen Ruppel, RN</p> <p>Census bed type: SNF/NF: 25 Total: 25</p> <p>Census payor type: Medicare: 1 Medicaid: 19 Other: 5</p>	F0000	<p>May 2, 2012</p> <p>Ms. Brenda Meredith, Area Supervisor Division of Long Term Care INDIANA STATE DEPARTMENT OF HEALTH 2 North Meridian Street, Section 4-B Indianapolis, Indiana 46204-3006</p> <p>RE: <b>Hickory Creek at Kendallville</b></p> <p style="text-align: center;"><b>Provider</b> <b>No: 15-5392</b> <b>Survey Event ID 4HGL11</b></p> <p>Dear Ms. Meredith:</p> <p>Attached for your review and anticipated approval, you will find the completed form CMS - 2567L Statement of Deficiencies and Plan of Correction for the recent Complaint Survey conducted from April 17, 2012 thru April 20, 2012, at Hickory Creek at Kendallville; Kendallville, Indiana.</p> <p>Please be advised that it is our intent to have this plan of correction also serve as our Allegation of Compliance. Compliance is effective on May 19, 2012.</p> <p>Should you have questions</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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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	<p>Total: 25</p> <p>Sample: 5</p> <p>Supplemental sample: 5</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 4/20/12 by Suzanne Williams, RN</p>		<p>regarding the attached Plan of Correction / Allegation of Compliance, then please do not hesitate to contact me.</p> <p>Sincerely,</p> <p>Laura Etter Administrator</p>		

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</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>Based on interviews and record review, the facility failed to notify the physician when the blood glucose level was beyond the parameters specified by the physician. This deficient practice affected 1 of 2</p>	F0157	F 157 It is the standard of practice and policy of this facility to notify the physician when a resident's condition changes, including blood glucose results outside the	05/19/2012			

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	<p>diabetic residents in a sample of 5 and 1 resident in a supplemental sample of 5. Residents F and J.</p> <p>Findings include:</p> <p>1. The clinical record of Resident F was reviewed, on 4/17/12 at 5:00 p.m., and indicated the resident was an insulin dependent diabetic.</p> <p>Physician's orders, dated 10/20/11, indicated blood glucose levels were to be checked before meals and at bedtime. The order indicated the physician was to be notified if the levels were over 350 or under 70.</p> <p>Review of the Medication Administration Record (MAR), on 4/17/12 at 5:30 p.m., indicated the resident's blood glucose had been 56 on 4/10/12 at 4:00 p.m., and 54 on 4/11/12 at 4:00 p.m. The blood glucose at 6:00 a.m., on 4/12/12 was recorded as 61. There was no documentation to indicate the physician had been notified. The Glucometer Blood Sugar Check record indicated the nurse had given a cookie and juice on 4/10/12 at 4:00 p.m., a soda on 4/11/12 at 4:00 p.m., and orange juice with toast on 4/12/12 at 6:00 a.m. There was no further documentation in nurses notes regarding the resident's condition the three times the</p>		<p>parameters specified by the physician.</p> <p><u>1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>The nurses that did not follow proper procedures were re-trained on the blood glucose policy and physician notification including notification when residents have blood glucose levels outside specified parameters. In addition, the nurses who failed to follow the established policies received written counseling. All nurses were in-serviced on the facility's policy regarding hypoglycemia and related procedures including use of the blood glucose log on April 18, 2012.</p> <p><u>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</u></p> <p>All diabetic residents have been reviewed to make sure that the physician has given specific parameters for notification of abnormal glucose levels. The hypoglycemic policy has been placed in front of the medication administration record for each diabetic resident, as a reference for the nurses as they obtain blood glucose readings.</p> <p>If the DON or designee finds that the nurses have not notified the physician of abnormal blood sugar</p>				

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	<p>blood glucose was low.</p> <p>During an interview with the Director of Nursing (DON) on 4/17/12 at 5:40 p.m., she was unsure why the order to notify the physician had not been followed.</p> <p>2. The MAR for diabetic Resident J was reviewed, on 4/18/12 at 10:00 a.m., and indicated the physician had written an order, on 1/19/12, to be notified if the resident's blood glucose was below 60 or above 450.</p> <p>The Glucometer Blood Sugar Check sheet indicated orange juice, a cookie and shake had been give at 4:00 p.m., on 4/9/12 for a blood glucose level of 45. No further documentation was available for review to indicate the physician had been made aware of the low blood glucose level or if the resident had experienced any additional symptoms of low blood glucose.</p> <p>The DON checked fax reports and communication information, on 4/18/12 at 10:30 a.m., and could find no indication the physician had been notified.</p> <p>This federal tag relates to Complaints IN00106240 and IN00106364.</p>		<p>readings, she will make sure that the physician is updated as soon as possible in regards to the resident's condition. Once the resident is cared for, the DON will review the facility's policy and procedure for hypoglycemia with the nurses involved. Progressive disciplinary action will be done, as well, for continued noncompliance.</p> <p><u>3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>The DON will review the 24 hour report and focus charting during each tour of duty at least 5 days a week. She will bring the results of these reviews to the morning interdisciplinary management meeting which occurs at least 5 days a week for further review and discussion by the IDT (interdisciplinary team). Any changes in approach or interventions will be added to the resident's care plan and the CNA assignment sheet at that time. This activity will occur on an ongoing basis.</p> <p>In addition, the DON or designee will audit the blood glucose log daily five times per week for one month, then three times per week for one month, then one time per week for one month to ensure that proper procedures and physician notification is being done appropriately</p>		

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	3.1-5(a)(2) 3.1-5(a)(3)		4. How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? The DON will bring the results of blood glucose log audits to the monthly meeting of the Quality Assurance Committee for 90 days for further recommendations or until 100% compliance is attained. The DON or designee will continue to audit on an ongoing basis and will report to the committee as directed by the committee members. <u>Date of Compliance: May 19, 2012</u>		

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interviews and record review, the facility failed to follow the facility's hypoglycemic protocol when the blood glucose level was below the parameters specified by the physician. This deficit practice affected 1 of 2 diabetic residents in a sample of 5 and 1 resident in a supplemental sample of 5. Residents F and J.</p> <p>Findings include:</p> <p>1. The clinical record of Resident F was reviewed, on 4/17/12 at 5:00 p.m., and indicated the resident was an insulin dependent diabetic.</p> <p>Physician's orders, dated 10/20/11, indicated blood glucose levels were to be checked before meals and at bedtime. The order indicated the physician was to be notified if the levels were over 350 or under 70.</p> <p>Review of the Medication Administration Record (MAR), on 4/17/12 at 5:30 p.m.,</p>	F0309	<p>F309 It is the standard of practice and policy of this facility to notify the physician when a resident's condition changes, including blood glucose results outside the parameters specified by the physician.</p> <p><u>1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u> The nurses that did not follow proper procedures were re-trained on the blood glucose policy and physician notification including notification when residents have blood glucose levels outside specified parameters. In addition, the nurses who failed to follow the established policies received written counseling. All nurses were in-serviced on the facility's policy regarding hypoglycemia and related procedures including use of the blood glucose log on April 18, 2012.</p> <p><u>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be</u></p>	05/19/2012			

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	<p>indicated the resident's blood glucose had been 56 on 4/10/12 at 4:00 p.m., and 54 on 4/11/12 at 4:00 p.m. The blood glucose at 6:00 a.m., on 4/12/12 was recorded as 61. There was no documentation to indicate the physician had been notified. The Glucometer Blood Sugar Check record indicated the nurse had given a cookie and juice on 4/10/12 at 4:00 p.m., a soda on 4/11/12 at 4:00 p.m., and orange juice with toast on 4/12/12 at 6:00 a.m. There was no further documentation in nurses notes regarding the resident's condition the three times the blood glucose was low.</p> <p>2. The MAR for diabetic Resident J was reviewed, on 4/18/12 at 10:00 a.m., and indicated the physician had written an order, on 1/19/12, to be notified if the resident's blood glucose was below 60 or above 450.</p> <p>The Glucometer Blood Sugar Check sheet indicated orange juice, a cookie and shake had been give at 4:00 p.m., on 4/9/12 for a blood glucose level of 45. No further documentation was available for review to indicate the physician had been made aware of the low blood glucose level or if the resident had experienced any additional symptoms of low blood glucose.</p>		<p><u>taken?</u></p> <p>All diabetic residents have been reviewed to make sure that the physician has given specific parameters for notification of abnormal glucose levels. The hypoglycemic policy has been placed in front of the medication administration record for each diabetic resident, as a reference for the nurses as they obtain blood glucose readings.</p> <p>If the DON or designee finds that the nurses have not notified the physician of abnormal blood sugar readings, she will make sure that the physician is updated as soon as possible in regards to the resident's condition. Once the resident is cared for, the DON will review the facility's policy and procedure for hypoglycemia with the nurses involved. Progressive disciplinary action will be done, as well, for continued noncompliance.</p> <p><u>3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>The DON will review the 24 hour report and focus charting during each tour of duty at least 5 days a week. She will bring the results of these reviews to the morning interdisciplinary management meeting which occurs at least 5 days a week for further review and discussion by the IDT (interdisciplinary team). Any</p>				

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	<p>3. The facility's Hypoglycemic Reaction Policy and Procedure, dated June 2004, was provided by the DON, on 4/17/12 at 10:30 a.m., and indicated, in part: "2. Give some form of glucose if resident is conscious. 3. Take vital signs. 4. Repeat fingerstick 15 minutes after first item of food is given."</p> <p>There was no documentation to indicate the follow up blood glucose checks or vital signs had been done for either of the two residents when their blood glucose levels were below the parameters specified by the physician for notification.</p> <p>This Federal tag relates to Complaints IN00106240 and IN00106364.</p> <p>3.1-37(a)</p>		<p>changes in approach or interventions will be added to the resident's care plan and the CNA assignment sheet at that time. This activity will occur on an ongoing basis.</p> <p>In addition, the DON or designee will audit the blood glucose log daily five times per week for one month, then three times per week for one month, then one time per week for one month to ensure that proper procedures and physician notification is being done appropriately</p> <p><u>4.How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?</u></p> <p>The DON will bring the results of blood glucose log audits to the monthly meeting of the Quality Assurance Committee for 90 days for further recommendations or until 100% compliance is attained. The DON or designee will continue to audit on an ongoing basis and will report to the committee as directed by the committee members.</p> <p><u>Date of Compliance: May 19, 2012</u></p>		

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interviews and record review, the facility failed to ensure 2 of 3 residents observed being transferred by a stand lift, in a sample of 5, were transferred in an environment as free of accident hazards as possible. Residents D and C.</p> <p>Findings include:</p> <p>1. During the orientation tour, on 4/17/12 at 9:40 a.m., the Director of Nursing (DON) identified Resident D as having an open area on the right ankle. The DON indicated she thought the area was the result of trauma from the stand lift being used to transfer her.</p> <p>The stand lift was observed in the hall outside the bathroom on the north hall. The foot plate was covered with a broken plastic cover which had a 4 inch piece missing on the right side and a 1 inch piece missing on the left side. The areas were sharp to touch and when lifted, the plastic liner of the foot plate was discolored with rust and dirt. The right</p>	F0323	<p>F323 It is the standard and policy of the facility to provide safe equipment for use of resident care and to ensure that all staff is continually educated on the proper techniques on how to utilize the equipment appropriately and safely. <u>1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u> Resident D is being monitored for open area on right ankle to ensure healing and appropriate treatments are being provided. Resident C is no longer residing at facility but bruise found on resident was healed and an intervention was put in place to prevent further incidents from occurring. All residents are to be transferred with shoes on and all staff was educated on April 18, 2012 as to proper transferring techniques of residents using the sit to stand lift. The lift was repaired on April 19, 2012 and does not have sharp edges and all equipment for the lift is working appropriately. <u>2.How other residents having the potential to be affected by the same deficient practice will be identified</u></p>	05/19/2012			

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	<p>support leg of the lift had a missing cover with broken plastic protruding. It was sharp to touch.</p> <p>The transfer of Resident D was observed, on 4/17/12 at 10:25 a.m. CNA #12 and CNA #13 transferred Resident D from the wheel chair to the toilet. When the resident was placed on the stand lift, both of her feet were not fully on the foot plate of the lift and her lower legs were not in contact with the leg pads. The leg pads on the lift were to stabilize the resident and provide support during the move from sitting to standing position. The resident's feet were half way on the foot plate, with the center bottom of both feet resting on the broken plastic cover of the foot plate. She was wearing slipper socks at the time.</p> <p>The clinical record of Resident D was reviewed, on 4/17/12 at 12:45 p.m., and indicated she had been admitted to the facility 11/4/11, with diagnoses including, but not limited to: Cerebral Palsy, pressure area of the buttocks and ankle and supra pubic catheter.</p> <p>The Deep Tissue Injury Assessment indicated an area on the right ankle was observed on 3/27/12 and was identified as stage II. On 4/17/12 at 4:10 p.m., accompanied by the DON, the area was</p>		<p><u>and what corrective action will be taken?</u></p> <p>No other residents were affected by this deficient practice. A refurbish kit was ordered on April 18, 2012 and received on April 19, 2012 to fix sit to stand lift and to ensure the equipment was safe and could be used in a safe manner for residents requiring this method of transfer. If the Administrator, DON, or other department manager observes that the lift is being used improperly, he/she will stop the staff immediately. The Administrator or DON will then retrain the staff in the appropriate procedure and observe a return demonstration at that time. Once the resident is cared for safely, the DON will render disciplinary action for continued noncompliance. If the lift is found not to be in good repair, the Administrator or department manager will stop the transfer process immediately. The DON or Administrator will then supervise the staff performing a safe alternative transfer. Once the resident's safety is assured, the lift will be inspected regarding the need for repair or replacement. The staff will be given disciplinary action appropriate to the circumstance.</p> <p><u>3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>A copy of guidelines for the sit to stand lift will be attached to the</p>		

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	<p>covered with Aquacel AG and a Mepilex dressing.</p> <p>During an interview with the physical therapist, on 4/17/12 at 4:00 p.m., he indicated when the stand lift was being used, the resident's legs should be against the leg pads for support.</p> <p>During an interview with the DON, on 4/17/12 at 4:10 p.m., she indicated the resident had been admitted with pressure areas, which had healed, and the current area was new. She indicated she thought the resident had scraped or bumped the ankle on the stand lift.</p> <p>Resident D was observed during a second transfer, on 4/18/12 at 8:50 a.m. The DON and CNA #13 placed the resident's feet on the foot plate and moved her forward enough for her legs to rest against the leg supports. The foot plate cover had not been replaced and remained sharp to touch. The resident was wearing slippers at the time.</p> <p>2. During the orientation tour, on 4/17/12 at 9:40 a.m., the DON identified Resident C as having a bruise on his left heel. She indicated she thought the bruise was due to having no shoes on while being transferred with the stand lift.</p>		<p>mechanical lift for staff reference for appropriate positioning of resident. DON or designee will observe all nursing staff utilizing a skills check sheet on proper techniques of transfers while using this lift. DON or designee will audit three times per week for 90 days using a skills check sheet for continued compliance and performance of proper mechanics and lifting techniques. Any identified issues or concerns with the use of the lift will be addressed as indicated in question #2.</p> <p>The Maintenance Supervisor will check the mechanical lift to make sure that it is working properly at least monthly as part of the facility's preventive maintenance program. He will report any issues affecting its operation immediately to the Administrator and will make sure that repairs are done as directed by the Administrator.</p> <p><u>4.How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?</u></p> <p>The Administrator and DON will bring the results of the return demonstrations and the preventive maintenance checks of the lift including any issues or concerns to the monthly Quality Assurance Committee for further review. At the end of the 90 day observation period and when 100% compliance</p>				

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	<p>The clinical record of Resident C was reviewed on 4/17/12 at 11:00 a.m. Nursing notes, dated 2/29/12 at 9:00 a.m., indicated the resident had a 1 cm by 1 cm bruise on the left heel.</p> <p>Resident C was observed being transferred, on 4/17/12 at 11:25 a.m. CNA #12 and LPN #11 were moving the resident. The resident was wearing shoes and had his feet on the foot pad. His legs were not touching the leg supports of the lift during the transfer.</p> <p>The Administrator provided a checklist for the use of the stand lift, on 4/17/12 at 3:00 p.m. The information on the list indicated, in part, "Have resident place feet on the foot support plate with shins against the shin support pad."</p> <p>This Federal tag relates to complaint IN00106240 and IN00106364.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p>		<p>is achieved, the QA Committee may decide to stop the documented observations. However, the preventive maintenance checks and random observations by the DON will continue on an ongoing basis.</p> <p><u>Date of Compliance: May 19, 2012</u></p>				

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F0354 SS=C	<p>483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.</p> <p>Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.</p> <p>The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.</p> <p>Based interview and record review, the facility failed to provided the services of a registered nurse for eight consecutive hours seven days each week on 2 of 36 days reviewed.</p> <p>This deficiency had the potential to affect all 25 residents in the facility.</p> <p>Findings include:</p> <p>On 4/17/12 at 3:00 p.m., the facility's nursing schedules, between 3/11/12 and 4/16/12, were reviewed with the DON (Director of Nursing).</p> <p>There was no documentation a registered nurse worked for eight consecutive hours on 4/14/12 and 4/15/12.</p> <p>On 4/18/12 at 11:00 a.m., the DON indicated one of the facility's registered</p>	F0354	<p>F354 It is the standard of this facility to provide services of a registered nurse for at least 8 consecutive hours a day seven days a week. <u>1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u> There were no residents affected by this practice; however, the Administrator will review the requirement for 8 consecutive hours of an RN in the facility 7 days a week. <u>2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</u> No residents were affected by this deficient practice. The current work schedule has been revised to ensure</p>	05/19/2012			

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	<p>nurses had quit without notice. The DON indicated she had been on call on 4/14/12 through 4/15/12 and was in the facility briefly on Saturday, 4/14/12 but the facility did not have a registered nurse on duty for eight consecutive hours on either of the days.</p> <p>This Federal tag relates to Complaints IN00106240 and IN00106364.</p> <p>3.1-17(b)(3)</p>		<p>proper staffing of registered nurse coverage for 8 consecutive hours 7 days a week.</p> <p><u>3.What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?</u></p> <p>A schedule to ensure proper staffing of registered nurse coverage has been implemented immediately. The DON or designee will monitor staff schedules on a daily basis to ensure registered nurse coverage is in place for weekends as well as during week times. The DON will notify the Administrator immediately of any concerns that she may have over her ability to cover the schedule with 8 hour RN coverage for any day of the week. The Administrator and DON will work together at that time to procure RN coverage, including the use of temporary staffing if needed to meet the requirement.</p> <p><u>4.How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?</u></p> <p>The DON will bring any identified issues and concerns with the required registered nurse coverage to the Quality Assurance committee for further review at the monthly meetings. Any recommendations made by the committee will be followed up by the DON and the results of those recommendations</p>	

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			will be brought back to the next monthly QA meeting for discussion. This will occur on an ongoing basis. <u>Date of Compliance: May 19, 2012</u>	

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F0425 SS=E	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Based on interviews and record review, the facility failed to administer insulin coverage at appropriate times for 2 of 2 diabetic residents in a sample of 5 and 3 of 5 residents in a supplemental sample. Residents C, F, H, I and J.</p> <p>Findings include:</p> <p>1. The clinical record of Resident C was reviewed, on 4/17/12 at 11:00 a.m., and indicated the resident was an insulin dependent diabetic.</p> <p>Physician's orders, dated 9/7/10, indicated</p>	F0425	<p>F425</p> <p>It is the standard of this facility to administer medications as ordered by the Physician following manufacturer's guidelines.</p> <p><u>1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>Residents C, F, H, I, and J did not have negative effects due to the incident. On April 20, 2012 the DON initiated immediate changes in the time of blood glucose checks and follow-up insulin coverage administration. In addition, blood glucose checks and insulin coverage now coincide with meal times as</p>	04/20/2012

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	<p>the resident was to be given Novolog insulin coverage for blood glucose levels over 151. The order indicated the blood glucose levels were to be checked before meals and at bedtime.</p> <p>Review of the Medication Administration Record for the first 17 days of April 2012, indicated the resident had received coverage at 6:00 a.m., on 15 of the 17 days. The amounts recorded ranged from 2 to 3 units of insulin.</p> <p>2. Review of the clinical record of Resident F, on 4/17/12 at 5:00 p.m., indicated he was an insulin dependent diabetic.</p> <p>Physician's orders, dated 10/20/11, indicated the resident's blood glucose levels were to be checked before meals and at bedtime, with coverage of humulin 70/30 insulin to be administered for blood glucose levels over 121.</p> <p>Review of the MAR, for the first 13 days of April 2012, indicated he had been given coverage at 6:00 a.m., on 4 of the 13 days, ranging from 4 units to 10 units.</p> <p>3. Review of the MAR for Resident H, on 4/18/12 at 1:00 p.m., indicated she had been admitted to the facility on 4/13/12. Her admission orders included humalog</p>		<p>recommended by the manufacturers.</p> <p>All nurses were in-serviced on proper administration of insulin coverage and time frames in which to provide coverage and in checking blood sugars on April 18, 2012.</p> <p><u>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</u></p> <p>No other residents were affected by this practice. Physician orders were obtained for all residents receiving blood sugar checks and insulin coverage to ensure insulin is administered by following manufacturers' guidelines in relation to meal times for each resident who receives insulin. Licensed Nurses' shifts were adjusted to ensure timeliness of blood glucose checks and follow-up insulin coverage. If the DON or designee finds that blood glucose checks or insulin injections are not given in accordance with manufacturer's guidelines and/or physician orders, she will correct the situation immediately and make sure that the resident receives his/her blood glucose checks and insulin appropriately. Once the resident is taken care of, the DON will review the facility policy with the nurse involved. In addition, she will render progressive disciplinary action for noncompliance.</p>	

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	<p>insulin coverage for blood glucose levels over 121.</p> <p>The MAR indicated she had received the coverage on 4/15 and 4/16/12 at 6:00 a.m., in the amounts of 2 unit and 4 units.</p> <p>3. The MAR for Resident I was reviewed, on 4/18/12 at 1:10 p.m., and indicated she had been given Novolog insulin coverage for blood glucose levels over 121 at 6:00 a.m., on 18 of 18 days in April 2012. The amounts were recorded ranging from 2 units to 8 units, depending on the blood glucose level.</p> <p>4. Review of the MAR for Resident J, on 4/18/12 at 1:15 p.m., indicated she had been given Novolog insulin coverage for blood glucose levels above 200 at 6:00 a.m., on two occasions during the first 18 days of April 2012. The amount given was 1 unit each time.</p> <p>5. RN #6 was queried, on 4/18/12 at 1:00 p.m., about the time the morning coverage of insulin was being administered and she indicated the night shift did the glucometer checks and gave the insulin coverage before they left the facility at 6:00 a.m. each day.</p> <p>RN #6 provided a Physician's Desk Reference Nurses Drug Handbook, dated</p>		<p><u>3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?</u> The DON or designee will audit the blood glucose log daily five times per week for one month, then three times per week for one month, then one time per week for one month to ensure blood sugars are being checked at appropriate times and coverage is being given per manufacturing guidelines to coincide with meal times. Any identified issues will be addressed as indicated in question #2.</p> <p><u>4. How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place?</u> The DON will bring the results of blood glucose log audits to the monthly meeting of the Quality Assurance Committee for 90 days for further recommendations or until 100% compliance is attained. The DON or designee will continue to audit on an ongoing basis and will report to the committee as directed by the committee members. <u>Date of Compliance: April 20, 2012</u></p>		

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	<p>2011, at 1:30 p.m., on 4/18/12, which was available at the nursing desk. She indicated the pharmacy had provided the reference book as a guideline for medication information and administration. The information indicated Novolog should be administered 5 to 10 minutes before meals and the information regarding Humalog indicated it should be given within 15 minutes before or after the meal.</p> <p>The Administrator was queried, on 4/18/12 at 1:15 p.m., about the time the breakfast meal was served and she indicated the serving of breakfast was started at 7:00 a.m.</p> <p>This indicated the insulin coverage was being given 45 to 60 minutes earlier than the drug information handbook indicated.</p> <p>The DON was queried on 4/18/12 at 2:00 p.m., about the time lapse between the time the coverage was being given and the residents were served the morning meal. She indicated the glucometer checks and coverage would be changed to the day shift. She indicated none of the residents who had been given the coverage at 6:00 a.m., had experienced any hypoglycemic episodes as a result of the practice.</p>			

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	<p>On 4/19/12 at 5:40 a.m., the night nurse, LPN #10, was interviewed and indicated, on 4/18/12, she was told the night nurses would not be administering insulin coverage and the day nurses would now be checking the morning blood sugars and administering the morning insulin coverage.</p> <p>On 4/19/12 at 6:45 a.m., the DON (Director of Nursing) was observed checking blood sugars and at 7:00 a.m., staff began serving the breakfast meal.</p> <p>This Federal tag relates to Complaint IN00106240.</p> <p>3.1-25(e)(1)</p>				