STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DANVILLE REGIONAL REHABILITATION	255 MEADOW DR DANVILLE, IN 46122

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F0000	This visit was for the Investigation of Complaint IN00112794. Complaint IN00112794-Substantiated. Federal/state deficiencies related to the allegations are cited at F282. Survey date: 7/31, 8/1, & 8/2/2012 Facility number: 000057 Provider number: 155132 Aim Number: 100266570 Survey team: Lora Brettnacher, RN, TC Christi Davidson, RN Census bed type: SNF: 24 SNF/NF: 76 TOTAL: 100 Census by payor type: Medicare: 24 Medicaid: 68 Other: 8 Total: 100 Sample: 5 Supplemental sample: 3	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	This deficiency reflects state findings cited in accordance with 410 IAC 16.2. Quality review completed 8/6/12 Cathy Emswiller RN			

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			
	Based on observation, interview and record review the facility failed to follow physician's orders regarding accuchecks [obtaining blood sugar result from bedside instrument] for 2 of 2 residents in a supplemental sample reviewed for following physician orders in a total sample of 8. (#H, #I) Findings include: 1. The record for Resident #H was reviewed on 7/31/12 at 1:30 p.m. Diagnoses included, but were not limited to hypertension, insulin dependent diabetes mellitus and anxiety. A recapitulation dated for 7/01/12 through 7/31/12 with a physician's order originally dated 9/27/11 indicated, "...Accuchecks two times daily at 6AM and 4PM...." A physician's order dated 7/23/12 indicated, "...[sign for change] Humulin 70/30 [insulin] to 56 units q [every] AM...."	F0282	The submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. The Plan of Correction is prepared and executed solely because it is required by federall and state law.Residents H and I will have accuchecks taken, as ordered by their attending physician, prior to insulin being given.Alert and oriented residents were interviewed to ensure there were no other residents that did not have accucheck readings as per physician order.Directed 1:1 re-education has been completed for the Licensed Nurse in insulin administration.A one time review has been completed for current resident population to ensure accucheck readings are completed as per physician order. Licensed nurses have been re-educated regarding following physician orders, completing accuchecks as ordered, and in the event there is a blank, Licensed Nurses have been re-educated on not providing insulin injections until they have obtained a reading.It is the responsibility of the Licensed	08/27/2012

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	A Diabetic Flow Record maintained in the Medication Administration Record [MAR] binder for Resident #H, dated for July 2012, indicated on 7/31/12 Resident #H received Humulin 70/30 [insulin] 56 units subcutaneous at 7:00 a.m. in the right deltoid by LPN #2. A Diabetic Flow Record maintained in the MAR binder for Resident #H, dated for July 2012, indicated, "...Accuchecks two times daily at 6AM and 4PM...." The initial box and the blood sugar box for 7/31/12 for 6:00 a.m. was blank. During an interview on 7/31/12 at 1:25 p.m., Resident #H indicated an accucheck was not done before breakfast this morning. Resident #H indicated she received insulin this morning without an accucheck. 2. The record for Resident #I was reviewed on 7/31/12 at 1:35 p.m. Diagnoses included, but were not limited to severe chronic obstructive pulmonary disease, diabetes type II and hypertension. A recapitulation dated for 7/01/12 through 7/31/12 with a physician's order originally dated 2/13/12 indicated, "...Accuchecks 4 times daily...Novolog [insulin] 100 unit/ml [milliliter] vial: Inject SUB-Q		Nursing Staff to follow physician orders. The times of the accucheck readings have been reviewed and revised to ensure the nurse responsible for administering insulin is also responsible for obtaining the accucheck reading at the same time. The Licensed Nurses will be responsible to audit accucheck readings every shift times 14 days, with Unit Manager oversight. The Unit Manager/Designee will then be responsible to audit accucheck readings for completion daily for 30 days, and then weekly for 12 weeks. Any identified concern will be immediately addressed with 1:1 re-education and/or disciplinary action.The DON/Designee will be responsible to review the results of the audits weekly for 2 months, and then monthly thereafter. Results of the audits will be forwarded to the Quality Performance Improvement Committee monthly for review. Any further actions will be as deemed necessary by the QPI committee.	

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	[subcutaneous] per S Scale [sliding scale]... [sign for less than] 100 = 0 units 100 - 150 = 2 unit (sic) 151 - 200 = 4 unit (sic) 201 - 250 = 6 unit (sic)... 251 - 300 = 8 unit (sic) 301 - 350 = 10 uni (sic) 351 - 400 = 12 uni (sic)...." A Diabetic Flow Record maintained in the MAR binder for Resident #I, dated for July 2012, indicated, "...Accuchecks 4 times daily...." The initial box, the blood sugar box, the dose box and the site box for 7/31/12 at 6:00 a.m. was blank. The Diabetic Flow Record maintained in the MAR binder for Resident #I dated for July 2012, indicated at 11:00 a.m. on 7/31/12, Resident #I's blood sugar was 208, and she received 6 units [insulin] in the left deltoid. During an interview on 7/31/12 at 1:25 p.m., Resident #I indicated the morning accucheck was not done. Resident #I indicated she went and requested the staff to check her blood sugar before breakfast. Resident #I indicated she is independent in getting herself around the facility. During the initial facility tour on 7/31/12 at 10:15 a.m., the DoN indicated Resident			

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	#H and Resident #I were interviewable. During an interview on 7/31/12 at 1:45 p.m., the DoN indicated she was not aware the accuchecks scheduled for 6:00 a.m. for Resident #H and Resident #I were not done. She indicated, "I will look into it." During an interview on 7/31/12 at 3:10 p.m., Licensed Practical Nurse [LPN] #2 indicated the night shift nurses do the 6:00 a.m. accuchecks. During an interview on 7/31/12 at 3:12 p.m., the DoN indicated the night shift nurse responsible for obtaining the 6:00 a.m. accuchecks for Resident #H and Resident #I was an agency nurse. She indicated she would expect a nurse to know the results of an accucheck before administering insulin. During an interview on 8/1/12 at 2:45 p.m., the Regional Director of Operations was not able to reach the agency to interview the nurse that was caring for Resident #H and Resident #I on 7/31/12 at 6:00 a.m. During an interview on 8/2/12 at 8:50 a.m., information was requested from the Regional Director of Operations and the Regional Director of Clinical Operations			

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	to verify how many residents were in the care of the agency nurse and how many of those residents were scheduled for 6:00 a.m. accuchecks. During an interview on 8/2/12 at 10:01 a.m., the Regional Director of Clinical Operations indicated Resident #H and Resident # I were the only two residents in the care of the agency nurse that were scheduled to have a 6:00 a.m. accucheck on 7/31/12. During an interview on 8/2/12 at 10:51 a.m., the Regional Director of Clinical Operations indicated the agency nurse was contacted regarding the accuchecks ordered for Resident #H and Resident #I on 7/31/12 at 6:00 a.m., and no additional information or documentation was provided. This Federal tag relates to Complaint IN00112794. 3.1-35(g)(2)			