STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155267	A. BUILDING 00 B. WING	04/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT VILLA NURSING AND REHABILITATION CENTER	545 W MOONGLO RD SCOTTSBURG, IN 47170

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F000000	This visit was for the Investigation of Complaints IN00147280, IN00147345 and IN00147459. Complaint IN00147280 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282, F309 and F514. Complaint IN00147345 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F280, F282, F309 and F514. Complaint IN00147459 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282, F309 and F514. Survey dates: April 21, 22, and 23, 2014 Facility number: 000168 Provider number: 155267 AIM number: 100267020 Survey team: Virginia Terveer, RN, TC Julie Call, RN Martha Saull, RN Census bed type: SNF/NF: 56 Total: 56 Census payor type: Medicare: 8 Medicaid: 46 Other: 2 Total: 56	F000000	"This Plan of Correction consitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or an agreement with the deficiences or conclusions contained in the Department's inspection report."We respectfully request that your office will accept this plan as our facility's compliance and that you consider a desk reivew as the tags cited are not deemed to be actual harm or immediate jeapordy. Please review our attachments with the cited defiencies as an audit tool.If you have any questions, please contact me at (812) 752-3499. Thank you in advance for your immediate attention in this matter.	

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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	Sample: 6 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality Review completed on April 29, 2014, by Brenda Meredith, R.N.			
F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or			

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	interested family member. Based on interview and record review, the facility failed to ensure a physician was notified of a resident's weight gain (with a diagnosis of congestive heart failure) for 1 of 3 resident's reviewed for weight monitoring. Resident B Findings include: On 4/21/14 at 11 A.M., the clinical record of Resident B was reviewed. Diagnoses included, but were not limited to, the following: Acute and Chronic Respiratory Failure, morbid obesity, Peripheral Vascular Disease, Hyperlipidemia, Obstructive Sleep Apnea and Immobilization Syndrome, Chronic Kidney Disease, Anxiety, Depression, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Atrial Fibrillation and Diabetes Mellitus. On 4/23/14 at 12:35 P.M., the DON (Director of Nursing) was interviewed regarding the computerized "...Weights Detail Report" for Resident B. This report indicated the resident's weight on 2/10/14 was 349 lbs and on 3/7/14 the resident's weight was 368 lbs (an increase of 5.16%). The DON indicated at this time, the dietician had made a note on 3/5/14 which indicated the resident's current weight was 349 lbs and made the following note: "...is non-compliant with modifications. Will continue to encourage compliance and monitor." On 3/18/14 the FSM (food service manager) documented the following note: "current weight 368 lbs...above IBW (ideal body weight) range...receives diuretic and can affect weight...NAS (no added salt diet).	F000157	Resident B has been discharged.A one time audit of current resident population has been completed reviewing significant weight changes for March and April 2014. Staff have been re-educated on obtaining weights as per facility protocol or MD order and MD/Family notification of significant weight loss or weight gain. It is the responsibility of the Licensed Supervisory Nurses to document MD/resident/family notification of significant weight loss or gain. The DON/designee will audit weight monitoring weekly for 12 weeks, monthly for 3 months, and then quarterly for 2 quarters. Any issues identified will be immediately corrected, 1:1 re-education, up to and including disciplinary action as deemed appropriate. The ADM/Designee will be responsible to review the audits completed weekly/monthly. Results of the reviews will be forwarded to the Quality Performance Improvement Committee for review monthly for 6 months, and then quarterly times 2 quarters. Any additional actions will be as determined by the QPI committee.	05/09/2014

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	Will continue to monitor." The DON indicated the physician should have been notified on the 5.16% weight gain. Nurses notes were reviewed at the time for 3/4/15 - 3/17/14. Documentation was lacking of notification of physician and/or Nurse Practitioner of the above 5.16% increase in weight from 2/10/14 - 3/7/14. An SBAR (Situation Background and Recommendation) form was dated 3/11/14 and indicated the following: "...situation: increase in cough...L(left) foot swollen, 2+ pitting edema...other pertinent history...myocardial degeneration...." Documentation was lacking of notification to physician and/or nurse practitioner of 5.16% increase in weight. A physician progress note dated 3/18/14 indicated the resident had "no pitting edema today..." Documentation was lacking in the physician progress note of the recent increase in weight of 5.16%. On 4/23/14 at 2 P.M. the policy and procedure for "Notification of Resident Change in Condition" was received from the DON. This policy was dated July 2011 and included, but was not limited to, the following: "...If the change in the resident's condition is not crucial or significant...the resident's physician and family...will be notified at the earliest convenient time during regular business hours...Document in the Nurses notes the times notification was made and the names of the person(s) to whom you spoke...The nurse may use the "Interact II SBAR Communication Tool" (facility form used for communication) and Progress note as a physician notification and as a nurses note."			

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	This Federal tag relates to Complaint IN00147345.			
F000280 SS=D	3.1-5(a)(2) 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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 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.			
	Based on interview and record review, the facility failed to ensure a resident and/or family member was consistently informed of dates/times resident care planning conferences were to be held and/or ensure resident care plan conferences occurred as scheduled for 1 of 3 resident's reviewed for care plan conferences. Resident B Findings include:	F000280	Resident B has been discharged.A one time audit of current resident population has been completed reviewing care conference invitations for residents and families for March and April 2014. Staff have been re-educated on ensuring resident and family invitations are provided timely, and maintaining documentation of care conference invites. It is the responsibility of the Social Services staff to consistently inform resident and/or family of	05/09/2014

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	1. On 4/22/14 at 11:25 A.M., the SSD (Social Service Director) was interviewed. She indicated she had been employed by the facility since November 2013. She indicated notification of upcoming care plan meetings were to be sent to the primary contact person (listed on the face sheet of the clinical record) and also a copy given to the resident. The notification letter included, but was not limited to, the following: "...This is an opportunity for you to meet with the Social Worker and other interdisciplinary team members as needed to review the plan of care...these meetings are held every quarter..." The SSD indicated she mailed the notification to the primary contact person via regular mail and indicated she had not gotten any notifications returned to her via mail from this resident's primary contact. She indicated she kept a copy of the letter which was provided to the primary contact and the resident. She indicated she had not received a response from the resident's primary contact in regards to attending care plan meetings. She indicated Resident B was considered "her own person" to make decisions as she was alert and oriented. The SSD indicated the resident and/or her family had not attended any care plan meetings. On 4/22/14 at 1:45 P.M., the Administrator (ADM) was interviewed. She provided a "Care Plan Schedule" for the resident's care plan meetings. She indicated the resident had been admitted to the facility on 2/5/13. The care plan schedule included the following information: 2/12/13 admission; 3/15/14 readmission; 6/14/13 quarterly; 9/10/13 quarterly; 10/29/13 quarterly; 12/18/13 significant change and 3/18/14 quarterly. The ADM indicated the resident's face sheet listed (primary contact name) as		dates/times for resident care planning conferences. The ADM/designee will audit care planning conferences invitation completion weekly for 12 weeks, monthly for 3 months, and then quarterly for 2 quarters. Any issues identified will be immediately corrected, 1:1 re-education, up to and including disciplinary action as deemed appropriate. Results of the reviews will be forwarded to the Quality Performance Improvement Committee for review monthly for 6 months, and then quarterly times 2 quarters. Any additional actions will be as determined by the QPI committee.	

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	the daughter in law but (primary contact name) was actually the daughter. On 4/23/14 at 9:45 A.M., the SSD was interviewed. At the time, the Social Service notes (SSN) were reviewed. The SSD indicated documentation was lacking of the resident and/or family notified of and/or participated in an initial care plan meeting for February 2013 and the readmission care plan meeting for March 2013. At the time, the SSD indicated documentation was lacking of of a care conference having been held on 6/21/13 and/or a summary of the outcome and/or attendance. During the interview, the SSD provided a copy of the "Comprehensive Care Plan Review Summary" form dated 9/10/13. This form included, but was not limited to, the following information: "Care conference: resident invited, family invited, accepted...declined..." This entire area had been left blank. The only signature on this form was one RN. The SSD was unable to provide additional documentation at the time in regards to a care conference. The SSD was also unable to provide documentation the resident and/or responsible party had been notified of a care conference for October 2013. The SSD provided a "Comprehensive Care Plan Review Summary" dated 12/26/13. The only two signatures of staff on this form were identified by the SSD as being from the Activity Department and the MDS Nurse. Documentation was lacking of the SSD having attended the care plan review and/or Resident Care Conference. A "Social Service Progress Note" dated			

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	3/18/14 included, but was not limited to, the following information: "...plans of care were reviewed and updated as needed...resident invited, family/responsible party invited, date invited (this was left blank)...supportive family, visit often..." Documentation was lacking of the care conference letters, which the SSD indicated she kept a copy of, having been sent to the responsible party and/or provided to the resident. On 4/23/14 at 1:45 P.M., the DON (Director of Nursing) provided a current copy of the facility policy and procedure for "Resident/Family Conference", dated April 2012. This policy included, but was not limited to, the following: "...will encourage the resident and/or family...to attend the Resident Care Conference, which will be scheduled with the appropriate Interdisciplinary Team Members...Procedure...schedule a preliminary conference with the resident, family...using the appropriate care conference letter...discuss the plan of care goals with the resident, family...to ensure their needs are met...summarize the outcome of the meeting and document attendance...ensure notification of the resident and family...of the next scheduled Resident Care conference. Document notification and date of notification using the Social Service Progress notes." This Federal tag relates to Complaint IN00147345.			
F000282 SS=D	3.1-35(d)(2)(b) 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			

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	persons in accordance with each resident's written plan of care. 1. Based on interview and record review, the facility failed to ensure physician orders were followed in regards to oxygen for 1 of 2 residents reviewed for oxygen (Resident A). 2. Based on interview and record review, the facility failed to ensure resident's weights were obtained as ordered for 1 of 3 resident's reviewed for weight monitoring. (Resident B) 3. Based on interview and record review, the facility failed to ensure 1 of 1 resident reviewed with ACE (all cotton elastic) wraps had wraps applied as ordered. (Resident B) Findings include: 1. A review of Resident A's record began on 4-21-2014 at 2:30 p.m. The recapitulation for 3-29-2014 was signed by the physician on 3-30-2014. Diagnoses included but were not limited to, acute respiratory failure, CHF (congestive heart failure), pneumonia, diabetes, hypertension, asthma and COPD (chronic obstructive pulmonary disease). The physician orders indicated "O2 (oxygen) at 2 LPM (liters per minute) via N/C (nasal cannula) for COPD, asthma and CHF. A review of nursing progress notes by RN #1 dated 3-30-2014 at 9:00 a.m., indicated "...O2 at 3 LPM N/C...." A review of nursing progress notes by LPN #2 dated 3-31-2014 at 11:30 a.m., indicated "...O2...on 3 Liters...." A review of the MAR (Medication Administration Record) for 3-30-2014 and	F000282	Resident A has been discharged.Resident B has been discharged.A one time audit has been completed of current resident population reviewing Oxygen orders, weight monitoring, and ACE wrap application orders. Staff have been re-educated on following MD orders, and completing documentation as per expectation.It is the responsibility of the Licensed Supervisory Nurses to follow MD orders. The DON/designee will audit MAR/TAR documentation weekly for 12 weeks, monthly for 3 months, and then quarterly for 2 quarters. Any issues identified will be immediately corrected, 1:1 re-education, up to and including disciplinary action as deemed appropriate. The ADM/Designee will be responsible to review the audits completed weekly/monthly. Results of the reviews will be forwarded to the Quality Performance Improvement Committee for review monthly for 6 months, and then quarterly times 2 quarters. Any additional actions will be as determined by the QPI committee.	05/09/2014

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	3-31-2014 indicated RN #1 and LPN #2 documented their initials for the O2 at 2 LPM via N/C for their shifts. An interview with RN #1 on 4-22-2013 at 8:58 a.m., indicated residents on O2 would be placed on the liters of oxygen in the physician's orders. The nurse further indicated if the resident's oxygen saturation was low, the physician would be notified and the oxygen flow would be increased only if the physician gave the order. The nurse indicated the order would be in the resident's chart under the order tab. No physician orders were in Resident A's record for the 3 LPM rate. An interview with the DON (Director of Nursing) on 4-22-2014 at 11:25 a.m., indicated the orders signed by the physician on 3-30-2014 had the O2 at 2 LPM per N/C. The DON indicated she was unable to explain the documentation in the nurse progress notes of the 3 liters for the O2 on the 3-30-2014 9:00 a.m. by RN #1 or the 3-31-2014 11:30 a.m. entry of the 3 liters by LPN #2. The DON indicated if the O2 level was increased due to a low oxygen saturation level as a nursing measure, the nurse would have needed to obtain an order for the increase from the physician. An interview with LPN #2 on 4-23-2014 at 11:25 a.m., indicated Resident A was on 3 liters of O2 when her shift began and the LPN indicated she was unaware the oxygen order was for 2 LPM per N/C. 2. On 4/22/14 at 10 A.M., the clinical record			

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	of Resident B was reviewed. Diagnoses included, but were not limited to, the following: Congestive Heart Failure, Morbid Obesity, Edema. On 4/23/14 at 11 A.M. the DON (Director of Nursing) was interviewed. She indicated the resident was ordered to have daily weights obtained from 12/4/13 until the physician order was obtained on 1/6/14 to discontinue daily weights. On 4/23/14 at 1:30 P.M., the Medical Records clerk provided copies of the December TAR (treatment administration record) and the computerized Weight detail report. Documentation was lacking of daily weights having been obtained on the following dates: 12/6/13, 12/13/13 - 12/21/13, 12/23/13 - 12/25/13, 12/27/13 - 12/31/13 and 1/2/14 - 1/6/14. On 4/23/14 at 2:15 P.M. the DON was interviewed. She indicated she was unable to provide documentation of the missing daily weights from the above dates and the weights should have been done daily during the above time frames. 3. The clinical record of Resident B was reviewed on 4/22/14 at 10 A.M. Diagnoses included, but were not limited to, the following: Congestive Heart Failure, Immobilization Syndrome, Edema, peripheral vascular disease. On 4/23/14 at 11 A.M., the DON (Director of Nursing) provided a copy of the March and April 2014 TAR (treatment administration record). This form included, but was not limited to, the following: "...ACE (all cotton elastic) wrap to LLE (left lower			

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	extremity/edema." This order was dated 3/11/14. Documentation indicated application of the ACE leg wraps began on 3/12/14 and on 3/25/14 the resident had begun refusing the ACE leg wraps. The DON was interviewed at this time, and indicated the resident's refusal was indicated by the nurse circling her initials on the TAR. The DON indicated the resident's refusal of application of the ACE leg wraps began on 3/25/14 and continued to 3/31/14. At the time, the April 2014 TAR was also reviewed with the DON. She indicated at the time, documentation was lacking of any ACE wrap application and/or refusal for the dates the resident was at the facility in April (April 1-April 3). A procedure on documentation dated January 2004 provided by the Administrator on 4-23-2014 at 10:20 a.m., indicated "...will provide ongoing documentation of the resident's health status to include observations, assessments, interventions and clinical outcomes...includes but are not limited to...assessments...weights...narrative notes...medication/treatment...." This Federal tag relates to Complaints IN00147280, IN00147345 and IN00147459. 3.1-35(g)(2) 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			
F000309 SS=D				

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	care. Based on observation, interview and record review, the facility failed to ensure meals were provided within the recommended amount of time after fast acting insulin was administered for 1 of 3 residents (Resident #D) and the facility failed to ensure sliding scale insulin was given within an hour after the blood sugar was obtained for 1 of 3 residents (Resident #F) observed for diabetic management. Findings include: 1. A review of Resident D's clinical records began on 4-22-2014 at 9:00 a.m. and indicated her diagnoses included but were not limited to, diabetes mellitus Type II, coronary artery disease (CAD), hypertension (high blood pressure), dementia. Resident #D's BIMS (Brief Interview for Mental Status) was 12/15 which indicated she was alert and oriented. During an interview with Resident #D on 4/22/14 at 3:45 p.m., she indicated the nurses checked her blood sugar before she eats and she indicated she did not know when her insulin was given. She indicated the nurse takes care of that for her. During an observation on 4/22/14 at 4:45 p.m., RN #3 administered Humalog Insulin 3 units SQ (subcutaneous) to Resident #D into her right abdomen per MD order for sliding scale coverage. Resident #D was observed to independently propel herself in her wheelchair to her table in the back of the dining room. She was served a beverage of hot chocolate to drink at 5:05 p.m..	F000309	Residents D, E, and F are not known.A one time audit of current resident population has been completed reviewing fast acting insulin use and accucheck readings and sliding scale insulin coverage. Staff have been re-educated on administration of fast acting insulin with a meal or substantial snack and timely administration of sliding scale insulin coverage. It is the responsibility of the Licensed Supervisory Nurses to provide fast acting insulin timely with a meal or substantial snack and administer sliding scale insulin coverage within an hour of the accucheck reading. The DON/designee will audit insulin administration, scheduled at meal time or sliding scale coverage for 10% resident current population across shifts weekly for 12 weeks, monthly for 3 months, and then quarterly for 2 quarters. Any issues identified will be immediately corrected, 1:1 re-education, up to and including disciplinary action as deemed appropriate. The ADM/Designee will be responsible to review the audits completed weekly/monthly. Results of the reviews will be forwarded to the Quality Performance Improvement Committee for review monthly for 6 months, and then quarterly times 2 quarters. Any additional actions will be as determined by the QPI	05/09/2014

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	During an interview with RN #3 on 4/22/14 at 4:50 p.m., she indicated she administered Resident D's insulin after her blood sugar was checked and before Resident D would go to the dining room for supper. RN #3 did not indicate a specific amount of time before the resident should eat after receiving Humalog Insulin. During an interview with the DON (Director of Nursing) on 4/23/14 at 12:30 p.m., the DON indicated it was a nursing judgement on how soon the Resident's sliding scale insulin coverage is given. She indicated the it depended on the blood sugar level and the resident's condition. The DON indicated she was not aware of the guidelines for Humalog Insulin (a rapid acting insulin) which was to be given within 15 minutes of a meal or snack. The DON also indicated it would be very difficult to give all of the residents their insulin within 15 minutes of eating their meals. During an interview with RN #4 on 4/22/14 at 9:20 a.m., RN #4 indicated she gave Insulin to her residents 15-30 minutes before breakfast or as close to a meal time as she could. During the exit conference on 4/23/14 at 3:00 p.m., the Corporate Nurse indicated Humalog insulin could be administered up to 30 minutes before meals. 2. An interview with Resident #F (identified by the facility as alert, oriented and interviewable during the initial tour by LPN #5) on 4-22-2014 at 2:05 p.m., indicated meals were served within 15 - 30 minutes		committee.	

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	after the Humalog sliding scale insulin was administered. Resident #F indicated he has had problems with his blood sugar dropping quickly and had to have a jelly sandwich to bring up his blood sugar. A review of the Physician Orders for Resident #F on 4-23-2014 at 2:50 p.m., indicated the March 2014 recapitulation was signed by the physician on 3-18-2014. Diagnoses included but were not limited to, diabetes, end stage renal disease, diabetic neuropathy and dialysis. The Physician recapitulation for April 2014 indicated blood sugar checks before meals and at bedtime (6 a.m., 11 a.m., 4 p.m. and 8 p.m.) and Humalog 100/units per ml (milliliter) was ordered on a sliding scale (101 - 150 = 1 unit, 151 - 200 = 2 units, 201 - 250 = 3 units, 251 - 300 = 4 units, 301 - 350 = 5 units, 351 - 400 = 6 units and over 400 call MD)based on the results of the blood sugar. 3. An interview with Resident #E (identified as alert, oriented and interviewable during the initial tour by LPN #5) on 4-22-2014 at 2:05 p.m., indicated meals were served within 15 - 30 minutes after sliding scale insulin was received. An interview with the Administrator on 4/22/14 at 3:30 p.m., indicated the facility did not have a policy or procedure for diabetic management of blood glucose monitoring and insulin protocol. She indicated the facility used the Lippincott Manual of Nursing Practice 10th Edition. The Lippincott Manual of Nursing Practice Manual from pages 951 and 952 indicated the following: "...the rapid acting insulin (lispro-Humalog) is taken within 1 to 15 minutes before eating...."			

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	4. On 4/24/14 at 4:45 P.M., LPN #6 was interviewed. She indicated the residents who ate the evening meals in their rooms, were to receive their trays at approximately 4:45 P.M. She indicated Resident F usually ate his evening meal in his room and was to have received a blood glucose check (test to assess for resident's blood sugar level) at 4 P.M. She also indicated this resident received sliding scale insulin coverage (amount of insulin coverage determined in response to blood sugar levels obtained from the blood glucose check) based on the blood sugar result from the 4 P.M. blood glucose check. She indicated she was permitted to perform the blood glucose check an hour before the administration of the sliding scale insulin coverage. On 4/24/14 at 4:55 P.M., LPN #6 indicated she had performed the blood glucose check on this resident at 3:30 P.M. and the result was 158. She indicated in response to the resident's blood sugar, he was to have received 2 units of Humalog insulin (insulin with rapid onset). On 4/24/14 at 5 P.M., LPN #6 was observed to administer the Humalog insulin 100u/ml (units per milliliter), 2 units to the resident. The resident received his evening meal tray within minutes of having received his Humalog insulin. On 4/23/14 at 1 P.M., the DON (director of nursing) was interviewed. She indicated she was unsure of the acceptable timeframe in which to give sliding scale insulin after a blood sugar check but thought it would be the same as the time frame for administering medications after a designated time. She			

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	indicated this time frame was an hour. No additional documentation was provided at the time. This Federal tag relates to Complaints IN00147280, IN00147345 and IN00147459.			
F000514 SS=D	3.1-37(a) 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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. 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. Based on interview and interview, the facility failed to ensure documentation was complete for application of ace legs wraps for 1 of 1 resident reviewed for ace leg wraps (Resident B) and for accurate and complete documentation of blood sugar results, sliding scale insulin amounts and nursing progress notes times for 1 of 5 residents reviewed for blood sugar, sliding scale insulin documentation and nurse progress notes entries. (Resident A) Findings include: 1. The clinical record of Resident B was	F000514	Resident A has been discharged.Resident B has been discharged.A one time audit has been completed of current resident population reviewing accurate timing of medical record entries residents returning to the hospital, legible documentation of blood glucose results and dose of sliding scale insulin, and ACE wrap application orders for March and April 2014. Staff have been re-educated on ensuring documentation is complete via the MAR and TAR for diabetic monitoring and administration of insulin and treatments, legible	05/09/2014

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	reviewed on 4/22/14 at 10 A.M. Diagnoses included, but were not limited to, the following: Congestive Heart Failure, Immobilization Syndrome, Edema, peripheral vascular disease. On 4/23/14 at 11 A.M., the DON (Director of Nursing) provided a copy of the March and April 2014 TAR (treatment administration record). This form included, but was not limited to, the following: "...ACE (all cotton elastic) wrap to LLE (left lower extremity/edema." This order was dated 3/11/14. Documentation indicated application of the ACE leg wraps began on 3/12/14 and on 3/25/14 the resident had begun refusing the ACE leg wraps. The DON was interviewed at this time, and indicated the resident's refusal was indicated by the nurse circling her initials on the TAR. The DON indicated the resident's refusal of application of the ACE leg wraps began on 3/25/14 and continued to 3/31/14. At the time, the April 2014 TAR was also reviewed with the DON. She indicated at the time, documentation was lacking of any ACE wrap application and/or refusal for the dates the resident was at the facility in April (April 1-April 3). 2. Resident A's record was reviewed on 4-21-2014 at 2:30 p.m. The recapitulation for 3-29-2014 was signed by the physician on 3-30-2014. Diagnoses included but were not limited to, acute respiratory failure, CHF (congestive heart failure), pneumonia, diabetes, hypertension, asthma and COPD (chronic obstructive pulmonary disease). The physician orders indicated Resident A		entries, and accurate timing of chart entries. It is the responsibility of the Licensed Supervisory Nurses to ensure documentation is complete of treatments, entries are legible, and chart entries are recorded accurately. The DON/designee will audit MAR/TAR documentation weekly for 12 weeks, monthly for 3 months, and then quarterly for 2 quarters. Any issues identified will be immediately corrected, 1:1 re-education, up to and including disciplinary action as deemed appropriate. The ADM/Designee will be responsible to review the audits completed weekly/monthly. Results of the reviews will be forwarded to the Quality Performance Improvement Committee for review monthly for 6 months, and then quarterly times 2 quarters. Any additional actions will be as determined by the QPI committee.	

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	had blood sugar checks before meals and at bedtime with Humalog sliding scale insulin ordered as follows: 71 - 120 = 0, 121 - 150 = 1 unit, 151 - 200 = 2 units, 201 - 250 = 3 units, 251 - 300 = 4 units, 301 - 350 = 5 units, 351 - 400 = 6 units and greater than 400 give 6 units and call MD. A review of the MAR (Medication Administration Record) for March 31, 2014 indicated a blood sugar amount at 6:00 a.m. had the third number illegible ("14"). There was not an insulin amount documented but the site of the injection was indicated along with the nurse initials for LPN #7. An interview with the DON on 4-22-2014 at 11:25 a.m., indicated the DON was unable to read the blood sugar result on 3-31-2014 at 6 a.m. and the DON was unable to indicate what the zero with the slash mark through it meant. The DON indicated she would contact LPN #7. An interview with the DON on 4-23-2014 at 9:45 a.m., indicated LPN #7 was out of town but able to talk to her by phone. The DON indicated LPN #7 did not remember what the blood sugar result was for Resident A on 3-31-2014 at 6:00 a.m. without looking at the MAR. The DON indicated LPN #7 used the zero with the slash to indicate what site the Humalog insulin was administered. A review of the nursing progress notes entered by LPN #2, dated 3-31-2014 at 11:30 a.m. indicated vital signs, oxygen saturation and lung sounds were noted, the physician was contacted and orders were given to send the resident to Scott Memorial Hospital. A 12:00 p.m. entry by LPN #2 indicated Resident A was picked up by EMS and			

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	transported to Scott Hospital. A review of the EMS record for Resident #A obtained from the EMS on 4-22-2014 at 10:15 a.m. indicated the initial contact by the facility was on 3-31-2014 at 10:49 a.m. and Resident A left the facility at 11:14 a.m. A review of the Hospital Emergency Room report for Resident #A obtained from the Hospital Medical Records Department on 4-22-2014 at 10:25 a.m., indicated Resident #A was admitted on 3-31-2014 at 11:15 a.m. An interview with the DON on 4-22-2014 at 11:25 a.m., indicated the nursing progress notes documentation should reflect the actual time of the events. An interview with LPN #2 on 4-23-2014 at 11:25 a.m., indicated the time documented on Resident A's nurse progress notes for 3-31-2014 at 11:30 a.m. and 12:00 p.m. were within a minute of the actual time of the events. A procedure for documentation dated January 2004 provided by the Administrator on 4-23-2014 at 10:20 a.m. indicated "...document all calls to the physician...with actual names, dates and times..." This Federal tag relates to Complaints IN00147280, IN00147345 and IN00147459. 3.1-50(a)(1) 3.1-50(f)(2)			