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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155005 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>07/09/2012 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>MANORCARE HEALTH SERVICES | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1345 N MADISON AVE<br>ANDERSON, IN 46011 |
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| F0000              | <p>This visit was for the Investigation of Complaint IN00111044.</p> <p>Complaint IN00111044 - Substantiated. Federal/state deficiencies related to the allegations are cited at F282, F309, F360, and F514.</p> <p>Survey date: July 9, 2012</p> <p>Facility number: 000005<br/>Provider number: 155005<br/>AIM number: 100270840</p> <p>Surveyor: Jeri Curtis, RN</p> <p>Census bed type:<br/>SNF: 24<br/>SNF/NF: 127<br/>Total: 151</p> <p>Census payor type:<br/>Medicare: 24<br/>Medicaid: 110<br/>Other: 17<br/>Total: 151</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings in accordance with 410 IAC 16.2.</p> | F0000         | <p>July 27, 2012</p> <p>Long Term Care Division, 4th Floor 2<br/>North Meridian Street<br/>Indianapolis, IN 46204</p> <p>RE: ManorCare Health Services of Anderson<br/>1345 N. Madison Ave.<br/>Anderson, IN 46011</p> <p>Dear Kim Rhoades:</p> <p>Please note our plan of correction and allegation of compliance for the Complaint Survey completed July 9, 2012. We respectfully request a desk review. Should you have any other questions or need additional information, please contact me at the above address or (765) 644-2888. You may also contact me via email at <a href="mailto:421admin@hcr-manorcare.com">421admin@hcr-manorcare.com</a>.</p> <p>Sincerely,</p> <p>Nicole Fields, HFA<br/>Administrator</p> |                      |

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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|   | Quality review completed 7/12/12 by<br>Jennie Bartelt, RN.   |  |  |                            |  |

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| F0282<br>SS=D   | <p>483.20(k)(3)(ii)<br/>SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to provide care plan interventions of obtaining glucometer readings, providing the physician ordered diet, reporting symptoms of hyperglycemia, and evaluating and reporting ostomy abnormalities to the physician, for 1 (Resident A) of 3 residents among the sample of 4, reviewed for provision of care and physician orders.</p> <p>Findings include:</p> <p>The clinical record of Resident (A) was reviewed at 12:50 P.M., 7/9/12, and indicated a 6/18/12, admission with diagnoses including , diabetes, end stage renal disease with hemodialysis, and a partial colectomy with colostomy.</p> <p>A 6/18/12, physician order indicated a carbohydrate controlled diet and Humalog Insulin sliding scale coverage to be given 3 times a day before meals and at 8:00 P.M. .</p> <p>A 6/18/12, care plan concern addressed</p> | F0282   | <p><b>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:</b><br/>Resident A is discharged. RN #1 received one on one education related to guidelines for hyper/hypoglycemia and physician notification of changes in condition.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:</b><br/>A chart audit including MD orders and care plan reviews were completed to identify other residents having the potential to be affected by the same deficient practice. Audits included reviews for residents receiving blood glucose checks, insulin injections, ostomy evaluations and delivery of prescribed diet for dialysis residents while on leave to dialysis therapy.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b><br/>RN/LPN staff will be educated on</p> | 07/31/2012  |  |   |  |

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|   | <p>the potential of endocrine system complications related to insulin dependent diabetes. The goal was to minimize complications related to the disease process.</p> <p>Interventions included: obtaining glucometer readings as ordered; reporting abnormalities, providing the prescribed diet, and reporting signs and symptoms of hyperglycemia.</p> <p>A 6/19/12, care plan concern addressed an ostomy related to partial colectomy. The goal was the resident was to be maintained in as clean and dry dignified state as possible. Interventions included evaluation and treatment as necessary, and reporting any abnormalities, signs and symptoms of inflammation or pain to the physician.</p> <p>A 6/23/12, 7:30 A.M., nursing note documented by Registered Nurse (RN #1) indicated the blood sugar reading was HI (high). A call was placed to the physician. RN #1 documented the sliding scale coverage and Levemir Insulin were given.</p> <p>At 8:00 A.M., 6/23/12, RN #1 documented the blood sugar was re-checked following the sliding scale coverage and continued to be HI (high). .</p> <p>The 6/23/12, 9:00 A.M., nursing note</p> |   | <p>the following guidelines:</p> <ul style="list-style-type: none"> <li>·Hyperglycemia and Hypoglycemia Protocol and physician notification.</li> <li>·Providing meal or snack for dialysis residents while on leave to dialysis treatment center.</li> <li>·Evaluating and reporting ostomy abnormalities to the physician.</li> <li>·Following the resident's plan of care</li> </ul> <p><b>How the corrective actions will be monitored to ensure the deficient practice will not recur (QAA)</b></p> <p>Medication administration observations will be conducted at least twelve times per week by the Director of Care Delivery or Designee to monitor medication administration and documentation for management of hyper/hypoglycemia episodes, as care planned and per physicians order.</p> <p>The Director of Care Delivery or Designee to monitor weekly for documentation related to evaluation of stoma site per facility guidelines, plan of care and reporting any change of condition to physician.</p> <p>The Director of Care Delivery or Designee will audit at least five times per week to monitor and validate the delivery of sack meals or snacks for dialysis residents while on leave to dialysis therapy per care plan, facility guidelines and physicians order.</p> |   |  |   |  |

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|   | <p>indicated an additional 6 units of insulin was given and the blood sugar reading was still high. RN #1 indicated, "will check in with the resident."</p> <p>Documentation did not indicate the blood sugar was re-checked, nor if Resident (A) had signs or symptoms of hyperglycemia.</p> <p>The 9:30 A.M., 6/23/12, nursing note, indicated RN #1 was in the resident's room doing a treatment.</p> <p>RN #1 documented, "Resident states he feels better at this time." Documentation did not indicate a re-check of the blood sugar.</p> <p>The next documented nursing note was at 10:30 A.M., 6/23/12, and indicated the family of Resident (A ) was at the desk asking for a colostomy bag and for the blood sugar to be re-tested.</p> <p>Documentation indicated a new order was received to send Resident (A) to the emergency room. RN #1 documented when vital signs were obtained, (Resident A) stated it was hurting in the site of his incision (colostomy) when he coughed and in the right side. Documentation did not indicate an assessment of the colostomy site.</p> <p>Family Member #1 was interviewed by telephone at 1:10 P.M., 7/9/12, and</p> |   | <p>Audit findings will be presented to QA&amp;A committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of six months. QA&amp;A committee will review findings and determine need for further monitoring and/or education per the QA&amp;A process.</p> |   |  |   |  |

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|                    | <p>indicated she was told RN #1 did not re-check the blood sugar during the hyperglycemic crisis per facility protocol because (Resident A) had said he felt like it was going down and he felt better. Family member #1 also indicated on 6/23/12, she had requested RN #1 assess the colostomy because of loose adhesive about the seal, BM (bowel movement) drainage on the clothing, and protrusion of the stoma. Family member #1 indicated RN #1 ignored the concerns and Resident (A) was sent to the hospital 6/23/12, without ostomy care. Family Member #1 also indicated she had spoken with the Director of Nursing (DoN) the past week with a concern of the facility's failure to provide a meal prior to the 4:30 A.M., dialysis transfer time. Family member #1 indicated the DoN had said it would be taken care of, then during the week of the July 4th Holiday, meals were not provided prior to transfer, and the blood sugars were low.</p> <p>The DoN was interviewed at 3:15 P.M., 7/10/12, and indicated all care plan interventions were to be followed and documented.</p> <p>The Registered Dietician (RD #1) was interviewed at 4:30 P.M., 7/9/12, and indicated she knew there had been a problem with provision of an early meal</p> |               |   |                      |

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|   | <p>on dialysis days following the 6/23/12, hospitalization of Resident (A). RD #1 indicated the dietary staff had not been aware he had returned from the hospital and had not sent the early breakfast for 1-2 days around the 6/27/12, time period. RD #1 indicated she had investigated the failure to provide an early breakfast over the July 4th Holiday and found a dietary worker had not been doing her job. RD #1 indicated Resident (A) left for dialysis before the day kitchen staff came on duty. RD #1 indicated the evening staff were to prepare a sack breakfast and place it in the refrigerator for the day shift. RD #1 indicated the early breakfast had been prepared the week of July 4, however the day shift dietary worker on duty had not provided it to Resident (A). RD #1 indicated she was in the process of re-inservicing all dietary staff on the dialysis meal prep.</p> <p>The DoN provided the facility's 12/2009, Hyperglycemia Treatment Policy and the 4/7/06, Renal Dialysis-Carry Out Meals Policy on 7/9/12.</p> <p>The purpose of the Hyperglycemia Treatment Policy was to reduce the blood sugar as soon as possible. Procedure #13 indicated the blood glucose was to be monitored every 15 minutes until results were within normal limits for the resident</p> |   |   |   |  |   |  |

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|   | <p>or per physician orders. Suggested documentation included: blood glucose levels, clinical condition and vital signs.</p> <p>The Renal Dialysis Carry Out Meals Policy indicated residents were to have a meal provided to take with them when they were out of the facility during the meal hour. Guidelines #1 and #2 indicated the time of leaving and returning was to be determined and if a meal hour was included, a meal was to be provided at the facility or sent during transport. Guideline #5 indicated a system for delivering the meal to the nurse's station or resident prior to his/her leaving the facility was to be established. Note was made dialysis was scheduled at various hours and the type of meal and delivery time might be outside of regular kitchen hours. Guideline #7 indicated acceptance and appropriateness of the meal was to be validated with the transport and dialysis personnel.</p> <p>This federal tag relates to Complaint IN00111044.</p> <p>3.1-35(g)(2)</p> |   |   |                      |   |

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| F0309<br>SS=D   | <p>483.25<br/>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br/>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 observation, record review and interview, the facility failed to assure blood sugar monitoring, effect of sliding scale insulin coverage, and assessment of pain at the colostomy site for 1 (Resident A) of 3 residents among the sample of 4 reviewed for unstable diabetes.<br/>The facility also failed to ensure a meal was provided prior to dialysis for Resident (A).</p> <p>Findings include:</p> <p>Licensed Practical Nurse (LPN #1) was observed checking the blood sugar of Resident (A) at 11:45 A.M., 7/9/12. The glucometer reading was 464. LPN #1 called the attending physician and received an order to give 14 units of Humalog Insulin. LPN #1 administered the Insulin. LPN #1 indicated facility protocol for hyperglycemia was to monitor the blood sugar and vital signs every 15 minutes until the glucose was in normal range or the physician ordered no further re-checks. LPN #1 indicated she</p> | F0309   | <p><b>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:</b><br/>Resident A is discharged.<br/>RN #1 received one on one education related to guidelines for hyper/hypoglycemia and physician notification of changes in condition.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:</b><br/>A chart audit was completed to identify other residents having the potential to be affected by the same deficient practice. Chart audits of current residents receiving blood sugar monitoring and insulin coverage; documented assessment of ostomy sites, and delivery of prescribed diet for dialysis residents while on leave to dialysis therapy. MD orders update as necessary.</p> <p><b>What measures will be put into place or what systemic</b></p> | 07/31/2012  |  |   |  |

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|   | <p>would re-check the blood sugar of Resident (A) in 15 minutes and follow the sliding scale coverage, or call the physician again if it remained outside the parameters.</p> <p>The record of Resident (A) was reviewed at 12:50 P.M., 7/9/12, and indicated a 6/18/12, admission with diagnoses including , diabetes, end stage renal disease with hemodialysis, and a partial colectomy with colostomy.</p> <p>A 6/18/12, physician order indicated a Humalog Insulin sliding scale coverage to be given 3 times a day before meals and at 8:00 P.M. The sliding scale was as follows: 151-200-2 units; 201-250-4 units; 251-300-6 units; 301-350-8 units; 351-400-10 units; and greater than 401-12 units.</p> <p>The 6/18/12, physician orders included a parameter for coverage. Twelve units of Humalog Insulin was to be given and the physician notified if the blood sugar was 401 or greater.</p> <p>A 6/21/12, physician order indicated Levemir Insulin Flexpen 8 units was to be given twice daily at 8:00 A.M., and 8:00 P.M.</p> <p>A 6/23/12, 7:30 A.M., nursing note</p> |   | <p><b>changes will be made to ensure that the deficient practice does not recur:</b><br/>RN/LPN staff will be educated on the following:</p> <ul style="list-style-type: none"> <li>·Hyperglycemia, Hypoglycemia Protocol, and Blood Sugar monitoring</li> <li>·Documenting effects of sliding scale insulin coverage</li> <li>·Providing meal or snack for dialysis residents while on leave to dialysis treatment center.</li> <li>·Evaluating and reporting ostomy abnormalities to the physician.</li> <li>·Following the resident's plan of care.</li> </ul> <p><b>How the corrective actions will be monitored to ensure the deficient practice will not recur (QAA)</b><br/>Medication administration observations will be conducted at least twelve times per week by the Director of Care Delivery or Designee to monitor medication administration and documentation for management of hyper/hypoglycemia episodes, as care planned and per physicians order.<br/>The Director of Care Delivery or Designee to monitor weekly for documentation related to evaluation of stoma site per facility guidelines, plan of care and reporting any change of condition to physician.<br/>The Director of Care Delivery or Designee will audit at least five times per week to monitor and</p> |                      |   |

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|   | <p>documented by Registered Nurse (RN #1) indicated the blood sugar reading was HI (high). A call was placed to the physician. RN #1 documented the sliding scale coverage and Levemir Insulin were given, "at this time."</p> <p>At 8:00 A.M., 6/23/12, RN #1 documented the blood sugar was re-checked following the sliding scale coverage and continued to be HI. A call was placed to the physician.</p> <p>At 8:45 A.M., 6/23/12, RN #1 documented a new order was received to give an additional 6 units along with the sliding scale coverage for HI blood sugar.</p> <p>The 6/23/12, 9:00 A.M., nursing note indicated the additional 6 units was given and the blood sugar reading was still HI. "Will check in with the resident." Documentation did not indicate a re-check of the blood sugar, nor if Resident (A) experienced signs or symptoms of hyperglycemia.</p> <p>The 9:30 A.M., 6/23/12, nursing note, indicated RN #1 was in the resident's room doing a treatment. RN #1 documented, "Resident states he feels better at this time." Documentation did not indicate a re-check of the blood sugar.</p> |   | <p>validate the delivery of sack meals or snacks for dialysis residents while on leave to dialysis therapy per care plan, facility guidelines and physicians order.</p> <p>Audit findings will be presented to QA&amp;A committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of six months. QA&amp;A committee will review findings and determine need for further monitoring and/or education per the QA&amp;A process.</p> |                      |   |

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|  | <p>The next documented nursing note was at 10:30 A.M., 6/23/12, and indicated the family of Resident (A ) was at the desk asking for a colostomy bag and for the blood sugar to be re-tested. RN #1 documented, "gave the family a colostomy bag as requested and informed her (Family Member #1), I would be in room as soon as I finished with task that I was completing in a few minutes. While trying to finish note, Family member (#1) returned to desk and insisted that blood sugar be re-checked. Re-checked blood sugar. Reading HI. Nurse called MD. Nurse returned to cart and immediately drew up 12 units Humalog as ordered for blood sugar and administered. Call placed to all of MD's numbers at 10:45 A.M. Awaiting response. MD returned call at 11 A. M. and new order to send Resident to er (emergency room) at this time. Family notified. VSS (vital signs stable ). While obtaining vitals on resident. Resident stated that it is hurting in the site of his incision when he coughs at this time and in the right side. Report called to ER. EMAS (abbreviation used by RN #1 for emergency medical service) called for transport."</p> <p>Documentation indicated at 11:50 A.M., 6/23/12, the EMAS was at the facility to transport Resident (A) and family was at the bedside.</p> |  |  |  |
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|   | <p>The 6/23/12, transfer form documented by RN #1 indicated an unplanned transfer with a blood pressure of 174/74, pulse 85, respirations, 16, temperature 96.6, and oxygen saturation of 98% on room air. The reason for transfer was blood sugar of HI. Documentation indicated the most recent blood sugar was 193 at 4:30 P.M., 6/18/12.</p> <p>The 6/27/12, hospital discharge summary indicated Resident (A) was having increasing abdominal pain, nausea, vomiting, and coughing up yellowish green phlegm with a blood sugar above 500. Admission diagnoses included ketoacidosis, end stage renal disease, and pneumonia. Resident (A) was to return to the nursing facility and all nursing home medications were to be continued on the 6/27/12, discharge.</p> <p>Family Member #1 was interviewed by telephone at 1:10 P.M., 7/9/12, and indicated she had requested RN #1 no longer be allowed to care for Resident (A). Family member #1 indicated she had called the facility to complain of the failure of RN #1 to monitor the blood sugars on 6/23/12. Family member #1 indicated she was told the Director (DoN) of Nursing was on vacation. Family Member #1 indicated the Assistant</p> |   |   |   |  |   |  |

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|                    | <p>Director of Nursing (ADoN) returned a call 3 days later and set up a care plan meeting. Family Member #1 indicated she was told RN #1 did not re-check the blood sugar during the hyperglycemic crisis per facility protocol because (Resident A) had said he felt like it was going down and he felt better. Family Member #1 indicated she was told RN #1 had been re-educated on diabetic care. Family Member #1 indicated on 6/23/12, she had been arguing with RN #1 to re-check the blood sugar after the high reading and was told it would be checked again at the scheduled time of 11:00 A.M. Family Member #1 indicated she believed the facility had taken the 6/23/12, hyperglycemia episode and monitoring of blood sugars too lightly. Family member #1 indicated she had spoken with the Director of Nursing (DoN) the past week with a new concern of the facility's failure to provide a meal prior to the 4:30 A.M., dialysis transfer time. Family member #1 indicated the DoN had said it would be taken care of, then during the week of the July 4th Holiday, meals were not provided prior to transfer, and the blood sugars were low.</p> <p>RN #1 was interviewed at 3:15 P.M., 7/9/12, with the DoN present. RN #1 indicated on 6/23/12, she had gotten a blood sugar reading for Resident (A) as</p> |               |   |                      |

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|                    | <p>high at 7:30 A.M. RN #1 indicated she had called the physician and had given the insulin coverage as ordered. RN #1 indicated she believed she had re-checked the blood sugar twice before calling the physician. RN #1 indicated she was unsure if she had documented the blood sugar re-checks. RN #1 indicated at 8:00 A.M., the reading was still high after the insulin had been given. RN #1 indicated she had called the physician again and followed his orders.</p> <p>RN #1 indicated she had been in the room again at 9:30 A.M. (1 1/2 hours after the insulin coverage), and Resident (A) had said he felt like the blood sugar was going down. RN #1 indicated she forgot to re-check the blood sugar at that time. RN #1 indicated the family had been in and had requested the blood sugar be re-checked. RN #1 indicated she had re-checked it at 10:30 A. M., and it was still high. RN #1 indicated she had given Resident (A) an early lunch and the 12 units of insulin for a high reading, then notified the physician again. RN #1 indicated she had been re-educated on diabetic care twice and now knew she was to re-check a blood sugar every 15 minutes until it was within normal or within the given parameters ordered by the physician. RN #1 indicated she had been licensed in January of 2012, and the 6/23/12, episode was the first</p> |               |   |                      |

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|   | <p>hyperglycemia episode she had ever experienced. RN #1 indicated Resident (A) had not complained of pain until the EMS arrived for transfer. RN #1 indicated another nurse had assessed Resident (A) and had checked the lungs and abdomen prior to the hospital transfer. RN #1 indicated the other nurse had not said the bowel and lung sounds were abnormal. RN #1 indicated she did not document the lung or abdominal assessment because it had been completed by the other nurse.</p> <p>The DoN, who had been present during the 7/9/12, 3:15 P.M., interview with RN #1, indicated a high glucometer blood sugar reading meant it was greater than 500. The DoN also indicated the hypo/hyperglycemic protocols were available to all staff on the in house computer. The DoN indicated the monitoring of blood sugars and documentation in the clinical record and on transfer forms was to be accurate and complete. The DoN indicated she had been made aware of the failure to provide a meal to Resident (A) prior to the 4:30 A.M., transfers to dialysis. The DoN indicated she had spoken to staff about the concern and was unaware the early meals had not been provided recently.</p> <p>The Registered Dietician (RD #1) was</p> |   |   |   |  |   |  |

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|                    | <p>interviewed at 4:30 P.M., 7/9/12, and indicated she knew there had been a problem with provision of an early meal on dialysis days following the 6/23/12, hospitalization. RD #1 indicated the dietary staff had not been aware Resident (A) had returned from the hospital and had not sent the early breakfast for 1-2 days around the 6/27/12, time period. RD #1 indicated she had investigated the failure to provide an early breakfast over the July 4th Holiday and found a dietary worker had not been doing her job. RD #1 indicated Resident (A) left for dialysis before the day kitchen staff came on duty. RD #1 indicated the evening staff were to prepare a sack breakfast and place it in the refrigerator for the day shift. RD #1 indicated the early breakfast had been prepared the week of July 4, however the day shift dietary worker on duty had not provided it to Resident (A). RD #1 indicated she was in the process of re-inservicing all dietary staff on the dialysis meal prep.</p> <p>The DoN provided the facility's 12/2009, Hyperglycemia Treatment Policy and the 4/7/06, Renal Dialysis-Carry Out Meals Policy on 7/9/12.</p> <p>The purpose of the Hyperglycemia Treatment Policy was to reduce the blood sugar as soon as possible. Procedure #10</p> |               |   |                      |

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|   | <p>indicated the vital signs were to be monitored every 5-15 minutes until stable. Procedure #11 indicated the physician was to be kept advised of the blood sugar monitoring and the resident was not to be left alone. Procedure #12 indicated the physician's orders were to be verified and insulin to be administered as ordered. Procedure #13 indicated the blood glucose was to be monitored every 15 minutes until results were within normal limits for the resident or per physician orders. Suggested documentation included: blood glucose levels, clinical condition and vital signs; and subsequent interventions including communications with physician and family.</p> <p>The Renal Dialysis Carry Out Meals Policy indicated residents were to have a meal provided to take with them when they were out of the facility during the meal hour. Guidelines #1 and #2 indicated the time of leaving and returning was to be determined and if a meal hour was included, a meal was to be provided at the facility or sent during transport. Guideline #5 indicated a system for delivering the meal to the nurse's station or resident prior to his/her leaving the facility was to be established. Note was made dialysis was scheduled at various hours and the type of meal and</p> |   |   |                      |   |

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|   | <p>delivery time might be outside of regular kitchen hours. Guideline #7 indicated acceptance and appropriateness of the meal was to be validated with the transport and dialysis personnel.</p> <p>This federal tag relates to Complaint IN00111044.</p> <p>3.1-37(a)</p> |   |   |                      |   |

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| F0360<br>SS=D   | <p>483.35<br/>PROVIDED DIET MEETS NEEDS OF EACH RESIDENT</p> <p>The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.</p> <p>Based on record review and interview, the facility failed to ensure an early breakfast was provided prior to dialysis transport for 1 (Resident A) of 3 residents among the sample of 4 reviewed for nutritional status and diabetic care.</p> <p>Findings include:</p> <p>The record of Resident (A) was reviewed at 12:50 P.M., 7/9/12, and indicated a 6/18/12, admission with diagnoses including , diabetes, end stage renal disease with hemodialysis, and a partial colectomy with colostomy.</p> <p>Documentation indicated a 6/18/12, physician's order for a carbohydrate controlled diet.</p> <p>A 6/18/12, care plan concern addressed the potential of endocrine system complications related to insulin dependent diabetes. The goal was to minimize complications related to the disease process. Interventions included providing the diet per physician orders.</p> <p>Family Member #1 was interviewed by</p> | F0360   | <p><b>What correction actions(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <p>Resident A is discharged.<br/><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:</b></p> <p>A chart audit was completed to identify other residents having the potential to be affected by the same deficient practice. Audits included residents receiving hemodialysis.<br/><b>What measures will be put into place or what systemic changes will be made to ensure that the same deficient practice does not recur:</b></p> <p>Dietary staff will be educated on the guidelines for providing dialysis sack meal.<br/>Dietary worked received one on one education related to guidelines for providing dialysis sack meal.<br/><b>How the corrective actions(s) will be monitored to ensure the</b></p> | 07/31/2012  |  |   |  |

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|   | <p>telephone at 1:10 P.M., 7/9/12, and indicated she had spoken with the Director of Nursing (DoN) the past week with a concern of the facility's failure to provide a meal prior to the 4:30 A.M., dialysis transfer time. Family member #1 indicated the DoN had said it would be taken care of, then during the week of the July 4th Holiday, meals were not provided prior to transfer, and the blood sugars were low.</p> <p>The Director of Nursing (DoN) was interviewed at 3:15 P.M., 7/9/12, and indicated she had been made aware of the failure to provide a meal to Resident (A) prior to the 4:30 A.M., transfers to dialysis. The DoN indicated she had spoken to staff about the concern and was unaware the early meals had not been provided recently.</p> <p>The Registered Dietician (RD #1) was interviewed at 4:30 P.M., 7/9/12, and indicated she knew there had been a problem with provision of an early meal to Resident (A) on dialysis days following a 6/23/12, hospitalization. RD #1 indicated the dietary staff had not been aware Resident (A) had returned from the hospital and had not sent the early breakfast for 1-2 days around the 6/27/12, re-admission time period. RD #1 indicated she had investigated the failure</p> |   | <p><b>deficient practice will not recur; i.e. what quality assurance program will be put into place:</b></p> <p>The Registered Dietitian or Designee will audit at least five times per week to monitor and validate the delivery of sack meals or snacks for dialysis residents while on leave to dialysis therapy per physicians orders and facility guidelines. Audit findings will be presented to QA&amp;A committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of six months. QA&amp;A committee will review findings and determine need for further monitoring and/or education per the QA&amp;A process.</p> |   |  |   |  |

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|   | <p>to provide an early breakfast over the July 4th Holiday and found a dietary worker had not been doing her job. RD #1 indicated Resident (A) left for dialysis before the day kitchen staff came on duty. RD #1 indicated the evening staff were to prepare a sack breakfast and place it in the refrigerator for the day shift. RD #1 indicated the early breakfast had been prepared the week of July 4, however the day shift dietary worker on duty had not provided it to Resident (A). RD #1 indicated she was in the process of re-inservicing all dietary staff on the dialysis meal prep.</p> <p>The DoN provided the facility's 7/4/06, Renal Dialysis-Carry Out Meals Policy on 7/9/12.</p> <p>Review of the policy indicated the purpose of the policy was to ensure residents were provided a meal to take with them when they were out of the facility during the meal hour. Guidelines #1 and #2 indicated the time of leaving and returning was to be determined and if a meal hour was included, a meal was to be provided at the facility or sent during transport. Guideline #5 indicated a system for delivering the meal to the nurse's station or resident prior to his/her leaving the facility was to be established. Note was made dialysis was scheduled at various hours and the type of meal and</p> |   |   |   |  |   |  |

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|   | <p>delivery time might be outside of regular kitchen hours. Guideline #7 indicated acceptance and appropriateness of the meal was to be validated with the transport and dialysis personnel.</p> <p>This federal tag relates to Complaint IN00111044.</p> <p>3.1-20(a)</p> |   |   |                      |   |

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| F0514<br>SS=D   | <p>483.75(l)(1)<br/>RES<br/>RECORDS-COMPLETE/ACCURATE/ACCE<br/>SSIBLE<br/>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.</p> <p>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.</p> <p>Based on record review and interview, the facility failed to ensure accurate and complete documentation of blood glucose monitoring, and assessment of a change in condition for 1 (Resident A) of 3 residents among the sample of 4 reviewed for complete and accurate documentation.</p> <p>Findings include:</p> <p>The clinical record of Resident (A) was reviewed at 12:50 P.M., 7/9/12, and indicated a 6/18/12, admission with diagnoses including diabetes, end stage renal disease with hemodialysis, and a partial colectomy.</p> <p>A 6/18/12, physician order indicated a Humalog Insulin sliding scale coverage to be given 3 times a day before meals and at 8:00 P.M. The 6/18/12, physician</p> | F0514   | <p><b>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:</b><br/>Resident A is discharged.<br/><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:</b><br/>A chart audit was completed to identify other residents having the potential to be affected by the same deficient practice. Audits included residents receiving blood glucose checks, insulin injections and ostomy care.<br/><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b><br/>RN/LPN staff will be educated on the following:</p> | 07/31/2012  |  |   |  |

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|   | <p>orders included a parameter for coverage. Twelve units of Humalog Insulin was to be given and the physician notified if the blood sugar was 401 or greater.</p> <p>A 6/23/12, 7:30 A.M., nursing note documented by Registered Nurse (RN #1) indicated the blood sugar reading was HI (high). A call was placed to the physician. RN #1 documented the sliding scale coverage and Levemir Insulin were given.</p> <p>The 6/23/12, 9:00 A.M., nursing note indicated an additional 6 units was given per physician order and the blood sugar reading was still HI. Documentation indicated, "will check in with the resident."</p> <p>The 9:30 A.M., 6/23/12, nursing note, indicated RN #1 was in the resident's room doing a treatment. RN #1 documented, "Resident states he feels better at this time." Documentation did not indicate a re-check of the blood sugar, nor if Resident (A) experienced signs or symptoms of hyperglycemia.</p> <p>The 10:30 A.M., 6/23/12, nursing note indicated RN #1 called the MD. The MD returned a call at 11 A. M. with a new order to send Resident (A) to the emergency room. RN #1 documented while obtaining vital signs the resident</p> |   | <p>Alert Charting and change in condition documentation<br/><b>How the corrective actions will be monitored to ensure the deficient practice will not recur (QAA)</b><br/>ADNS or designee will monitor 5 times weekly the clinical record of residents who have a change in condition related to glucose monitoring to assure compliance with documentation guidelines. Audit findings will be presented to QA&amp;A committee weekly for 4 weeks and monthly thereafter. Ongoing monitoring will continue for a minimum of six months. QA&amp;A committee will review findings and determine need for further monitoring and/or education per the QA&amp;A process.</p> |   |  |   |  |

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|                    | <p>stated he was hurting in the site of his colostomy incision when he coughed and in the right side. Documentation did not indicate an assessment of the colostomy site, and abdomen nor breath sounds .</p> <p>Documentation indicated at 11:50 A.M., 6/23/12, the emergency medical service was at the facility to transport Resident (A). The 6/23/12, transfer form, documented by RN #1, indicated an unplanned transfer with a blood pressure of 174/74, pulse 85, respirations, 16, temperature 96.6, and oxygen saturation of 98% on room air. The reason for transfer was blood sugar of HI.</p> <p>Documentation indicated the most recent blood sugar was 193 at 4:30 P.M., 6/18/12.</p> <p>RN #1 was interviewed at 3:15 P.M., 7/9/12, with the DoN present. RN #1 indicated on 6/23/12, she had gotten a blood sugar reading for Resident (A) as high at 7:30 A.M. RN #1 indicated she had called the physician and had given the insulin coverage as ordered. RN #1 indicated she believed she had re-checked the blood sugar twice before calling the physician. RN #1 indicated she was unsure if she had documented the blood sugar re-checks. RN #1 indicated Resident (A) had not complained of pain until the EMS arrived for transfer. RN #1</p> |               |   |                      |

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|   | <p>indicated another nurse had assessed Resident (A) and had checked the lung and abdomen prior to the hospital transfer. RN #1 indicated the other nurse had not said the bowel and lung sounds were abnormal. RN #1 indicated she did not document the lung or abdominal assessments because it had been completed by the other nurse.</p> <p>The DoN, who had been present during the 7/9/12, 3:15 P.M., interview with RN #1, indicated the monitoring of blood sugars and documentation on transfer forms was to be accurate and complete.</p> <p>The DoN provided the facility's 12/2009, Hyperglycemia Treatment Policy on 7/9/12.</p> <p>Review of the policy indicated the purpose was to reduce the blood sugar as soon as possible. Procedure #13 indicated the blood glucose was to be monitored every 15 minutes until results were within normal limits for the resident or per physician orders. Suggested documentation included: blood glucose levels, clinical condition and vital signs; and subsequent interventions including communications with physician and family.</p> <p>This federal tag relates to Complaint IN00111044.</p> |   |   |   |  |   |  |

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|                          | 3.1-50(a)(1)<br>3.1-50(a)(2)   |                     |  |                            |