

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155242	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/05/2012
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-MUNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 29, 30, 31, June 1, 4, 5, 2012</p> <p>Facility number: 000146 Provider number: 155242 Aim number: 100291200</p> <p>Survey team: Ginger McNamee, RN, TC Betty Retherford, RN [May 29, 30, 31, June 4, 5, 2012 Karen Lewis, RN</p> <p>Census bed type: SNF/NF: 149 Total: 149</p> <p>Census payor type: Medicare: 23 Medicaid: 113 Other: 13 Total: 149</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed 6/11/12 Cathy Emswiller RN</p>	F0000		

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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F0250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on record review and interview, the facility failed to ensure each residents advanced directives were correctly identified by the social services staff and care planned in accordance with the family's wishes and physician's orders for 1 of 5 residents reviewed for continuity of advanced directives. (Resident # 208)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #208 was reviewed on 5/31/12 at 12:30 p.m.</p> <p>Diagnoses for Resident #208 included, but were not limited to, lewy body dementia, rheumatoid arthritis, depression, rheumatoid arthritis, and weakness.</p> <p>Admission orders, dated 2/18/12, indicated advanced directive status of Resident #208 was a "No code-DNR (do not resuscitate)" resident.</p>	F0250	<p>I. Resident #208's care plan was updated at the time of survey to accurately reflect the code status. II. An audit was conducted of all resident's code status orders, family wishes, and care plans to ensure all are accurate. No additional concerns were identified. III. Social Service staff have been re-educated relative to ensuring that advanced directives are correctly identified and care planned in accordance with family/resident wishes and physician's orders. IV. A performance improvement tool has been implemented to be used by Social Services to monitor for correct advanced directive care plans. This monitoring will be completed on an ongoing basis. The monitoring will occur during regularly scheduled care plan reviews, during MDS assessments and daily stand-up meeting for any new information related to any changes in condition and for any new admit. Social Services will receive copies of new orders to review any changes related to code status. Thus ongoing all residents will have this monitoring completed on a daily and quarterly basis. The Social</p>	06/20/2012			

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	<p>A physician's order, dated 3/15/12, indicated "change code status to Full Code per family (wife's) request." The code status was updated to a "full code" on subsequent recapitulations of physician's orders.</p> <p>A "Resident Progress Note," dated 5/24/12, indicated the interdisciplinary team met for a review of the resident's current plan of care. The note indicated the resident's wife was in attendance. The note indicated "S.S. reviewed Full Code status and residents wife wishes to continue."</p> <p>A health care plan problem, dated 3/15/12 and last reviewed on 5/24/12, indicated "DNR executed." Approaches for this problem included, but were not limited to "comfort measures as requested/as needed" and "No CPR [cardiopulmonary resuscitation] if heart or respirations cease."</p> <p>During an interview with the Administrator and Social Services Director (SSD) on 5/31/12 at 3:15 p.m., additional information was requested related to the discrepancy between the physician's orders and families request for a full code and the health care plan having been developed on 3/15/12 and updated</p>		Services Director will review findings daily and report to P.I. committee monthly for 6 months. V. Completion Date: June 20, 2012				

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	<p>on 5/24/12 indicating the resident was a "No Code."</p> <p>During an interview on 6/5/12 at 9:50 a.m., the SSD indicated she had looked at the wrong information when she created the health care plan on 3/15/12 and had not noted the discrepancy when the health care plans were reviewed on 5/24/12.</p> <p>Review of the current facility policy titled, Advance Directives, dated 10/31/06, provided by the Social Services Director on 6/5/12 at 8:50 a.m., included, but was not limited to, the following:</p> <p>"Rationale The resident has the right to establish advance directives as to his/her wishes regarding treatment options and end of life care.</p> <p>Procedure On admission, furnish the resident information regarding the right to accept of refuse treatment and the right to formulate an advance directive....</p> <p>9. Notify the designated health care agent orally and in writing of that determination....</p>						

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	<p>Revocation of Advance Directives</p> <p>12. If resident of designated health care agent indicates the wish to rescind any or all advance directives, obtain written confirmation and place on the resident's medical record....</p> <p>Documentation guidelines ...2. update resident's care plan, as needed."</p> <p>3.1-34(a)</p>				

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure a comprehensive plan of care was developed to ensure each residents advanced directives were followed in accordance with the family's wishes and physician's orders for 1 of 5 residents reviewed for health care planning of advanced directives. (Resident # 208)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #208 was reviewed on 5/31/12 at</p>	F0279	<p>I. Resident #208's care plan was updated at the time of survey to accurately reflect the code status. II. An audit was conducted of all resident's code status orders, family wishes, and care plans to ensure all are accurate. No additional concerns were identified. III. Social Service staff have been re-educated relative to ensuring that advanced directives are correctly identified and care planned in accordance with family/resident wishes and physician's orders. IV. A performance improvement tool has been implemented to be used by Social Services to</p>	06/20/2012			

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	<p>12:30 p.m.</p> <p>Diagnoses for Resident #208 included, but were not limited to, lewy body dementia, rheumatoid arthritis, depression, rheumatoid arthritis, and weakness.</p> <p>Admission orders, dated 2/18/12, indicated advanced directive status of Resident #208 was a "No code-DNR (do not resuscitate)" resident.</p> <p>A physician's order, dated 3/15/12, indicated "change code status to Full Code per family (wife's) request." The code status was updated to a "full code" on subsequent recapitulations of physician's orders.</p> <p>A "Resident Progress Note," dated 5/24/12, indicated the interdisciplinary team met for a review of the resident's current plan of care. The note indicated the resident's wife was in attendance. The note indicated "S.S. reviewed Full Code status and residents wife wishes to continue."</p> <p>A health care plan problem, dated 3/15/12 and last reviewed on 5/24/12, indicated "DNR executed." Approaches for this problem included, but were not limited to "comfort</p>		<p>monitor for correct advanced directive care plans. This monitoring will be completed on an ongoing basis during regularly scheduled care plan reviews and during daily stand-up meetings related to any changes in condition and for any new resident. Social Service will receive copies of new orders to review any changes related to code status and will immediately update the plan of care. Thus, ongoing, all residents will have this monitoring completed on a daily and quarterly basis. The Social Services Director will review findings daily and report to P.I. committee monthly for 6 months. V. Completion Date: June 20, 2012</p>		

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	<p>measures as requested/as needed" and "No CPR [cardiopulmonary resuscitation] if heart or respirations cease."</p> <p>During an interview with the Administrator and Social Services Director (SSD) on 5/31/12 at 3:15 p.m., additional information was requested related to the health care plan having been created in error on 3/15/12 and not corrected during the review on 5/24/12.</p> <p>During an interview on 6/5/12 at 9:50 a.m., the SSD indicated she had looked at the wrong information when she created the health care plan on 3/15/12 and had not noted the discrepancy when the health care plans were reviewed on 5/24/12.</p> <p>Review of the current facility policy, dated 1/7/12, titled "Care Plans", provided by the Director of Nursing on 6/5/12 at 9:00 a.m., included, but was not limited to, the following:</p> <p>"Policy A comprehensive care plan is developed consistent with the patient's specific conditions, risks, needs, behaviors, preferences and with standards of practice including measurable objectives,</p>			

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	<p>interventions/services, and timetables to meet the patient's needs as identified in the patient's assessment or as identified in relation to the patients' response to the interventions or changes in the patient's condition.</p> <p>Rationale:</p> <p>Plan of care is developed on the patient's individual needs as identified by assessments. The care plan includes a treatment plan, patients' preferences, patient goals that are measurable and contain a schedule to evaluate the patient's progress or lack of progress toward his/her goals....</p> <p>Components: ...3. The team of qualified persons monitors the patient's condition and effectiveness of the care plan interventions and revises the care plan quarterly, annually, with a significant change assessment or more frequently as needed with input by the patient and/or the representative...."</p> <p>3.1-35(a)</p>				

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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 record review and interview, the facility failed to ensure residents identified at risk for constipation received adequate bowel monitoring so that interventions ordered by the physician could be given as ordered for 2 of 10 residents reviewed for bowel monitoring. (Resident # 208 and #215)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #208 was reviewed on 5/31/12 at 12:30 p.m.</p> <p>Diagnoses for Resident #208 included, but were not limited to, lewy body dementia, rheumatoid arthritis and weakness.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 2/25/12, indicated Resident #208 was moderately cognitively impaired and required extensive assistance of the</p>	F0309	<p>I. BM records for Resident #'s 215 & 208 have been reviewed and no treatment for constipation was necessary for these residents. DNS/designee completed individual performance improvement counseling and re-education with the nurses responsible. II. All residents have the potential to be affected. Thus, this plan of correction applies to all residents. Administrative nurses/designees completed a facilitywide audit to ensure all residents had correct BM documentation with no concerns identified. III. Nursing staff have been re-educated relative to provision of necessary care and services, including but not limited to, existing policy and procedure related to BM monitoring/documentation, and the newly implemented BM protocol. IV. A performance improvement tool, "BM Monitoring" was implemented to be utilized by Nursing Administration, or designee, to monitor for correct BM monitoring and BM protocol compliance. The B.M. monitoring shall be</p>	06/20/2012			

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	<p>staff for toileting and transfers. The MDS indicated the resident was always incontinent of bowel.</p> <p>A health care plan problem, dated 2/18/12, and last reviewed on 3/29/12, indicated Resident #208 had a problem with impaired mobility. One of the goals for this problem was "normal bowel pattern." One of the approaches for this problem was "Monitor elimination pattern per policy."</p> <p>A recapitulation of physician's orders, dated 5/7/12, indicated Resident #208 had the following bowel related orders:</p> <p>Colace (a stool softener) 100 mg (milligrams) twice daily for constipation. The original date of this order was 4/11/12.</p> <p>Fleets enema (a chemical enema given to stimulate bowel evacuation) 133 ml (milliliters) 1 rectally every day as needed for constipation. The original date of this order was 2/18/12.</p> <p>Milk of Magnesia (MOM) (a laxative) 30 ml daily as needed for constipation. The original date of this order was 2/18/12.</p>		<p>conducted daily and will be ongoing to ensure compliance. The D.N.S. or designee will review findings weekly and shall report to P.I. committee monthly for 6 months to track and trend outcomes for compliance.</p>				

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	<p>May check for and remove soft stool as needed. The original date of this order was 2/18/12.</p> <p>The treatment administration records (TAR) (the record on which resident bowel movements were recorded) for March and April 2012 indicated the resident did not have a bowel movement for the following time periods:</p> <p>March 17-23, 2012- all zeros recorded. A time period of 7 days without a recorded bowel movement.</p> <p>April 12-25, 2012- all zeros recorded. A time period of 14 days without a recorded bowel movement.</p> <p>The nursing notes and medication administration records (MAR) lacked any information related to any MOM or Fleets enema having been given during these time periods. The MAR lacked any information related to the resident have been checked for an impaction during these time periods.</p> <p>During an interview with the Director of Nursing (DoN) and Unit Manager #1 on 6/4/12 at 12:40 p.m., additional information was requested related to the lack of bowel monitoring and</p>						

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	<p>administration of physician ordered interventions having been completed for the time periods noted above.</p> <p>During an interview on 6/4/12 at 12:40 p.m., Unit Manager #1 indicated she had no information to provide related to the lack of bowel monitoring for Resident # 208 noted above.</p> <p>2.) The clinical record for Resident #215 was reviewed on 5/31/12 at 2:55 p.m.</p> <p>Diagnoses for Resident #215 included, but were not limited to, the following: pulmonary embolism, sigmoid thickening, anemia, and chronic back pain.</p> <p>An admission Minimum Data Set (MDS) assessment, dated 3/13/12, indicated Resident #215 was moderately cognitively impaired and required assistance of the staff for toileting and transfers.</p> <p>A "Patient Nursing Evaluation," dated 3/6/12, indicated Resident #215 was physically reliant on a caregiver to go to the bathroom, used a stool softener, and usually had a bowel movement every 1-2 days.</p>						

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	<p>A health care plan problem, dated 3/15/12, indicated Resident #215 had a potential for constipation related to decreased mobility. One of the goals for this problem indicated the resident would have a soft formed bowel movement at least every three days. One of the approaches for this problem was "Monitor BM (bowel movement) records every shift."</p> <p>A recapitulation of physician's orders, dated 6/4/12, indicated Resident #215 had the following bowel related orders:</p> <p>Senokot (a stool softener) 8.6 mg one tablet twice daily for constipation. The original date of this order was 3/6/12.</p> <p>Metamucil 2 tablespoons powder in 4 ounces of water or juice daily for constipation. The original date of this order was 3/24/12.</p> <p>Fleets enema 133 ml 1 rectally every day as needed for constipation. The original date of this order was 3/6/12.</p> <p>Milk of Magnesia 30 ml daily as needed for constipation. The original date of this order was 3/6/12.</p> <p>May check for and remove soft stool</p>				

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	<p>as needed. The original date of this order was 2/18/12.</p> <p>The treatment administration records for March and May 2012 indicated the resident did not have a bowel movement for the following time periods:</p> <p>March 24-30, 2012- all zeros recorded. A time period of 6 days without a recorded bowel movement.</p> <p>May 16-23, 2012- all zeros recorded. A time period of 7 days without a recorded bowel movement.</p> <p>The nursing notes and medication administration records (MAR) lacked any information related to any MOM or Fleets enema having been given during these time periods. The MAR lacked any information related to the resident have been checked for an impaction during these time periods.</p> <p>During an interview with the Director of Nursing (DoN) and Unit Manager #1 on 6/4/12 at 2:30 p.m., additional information was requested related to the lack of bowel monitoring and administration of physician ordered interventions having been completed for the time periods noted above.</p>						

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	<p>The facility failed to provide any additional information related to the lack of bowel monitoring noted above as of exit on 6/5/12.</p> <p>3.) Review of the current facility policy, dated 11/18/05, titled "Bowel Elimination", provided by the Director of Nursing on 6/5/12 at 9:00 a.m., included, but was not limited to the following:</p> <p>"...Procedure</p> <p>21. Obtain a baseline bowel pattern record to determine if bowel output is excessive or inadequate.</p> <p>22. Develop treatment/retraining interventions tailored to the resident's needs.</p> <p>...25. Implement treatment/retraining interventions...."</p> <p>3.1-37(a)</p>			

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F0371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview, and record review, the facility failed to ensure hood vents were clean above the stove, the dish machine was delimed, and dietary staff did not recontaminate their hands during the hand washing process. These deficient practices had the potential to effect 143 of 143 residents that receive meals from the facility kitchen.</p> <p>Findings include:</p> <p>During a kitchen observation on 5/31/12 at 2:15 p.m., with the CDM present, the five vent screens above the stove had a black residue build up on them. The CDM indicated the vents were cleaned every six months by a professional company. There was an exposed open drain pipe on the floor next to the stove. The CDM indicated the drain was used for the steamtable that had been removed the week before.</p>	F0371	<p>I. The vent screens above the stove were professionally cleaned, as was previously scheduled, in accordance with the twice annual schedule, on 6/11/2012. The exposed drain pipe was covered with a cap at the time of survey. Since that time, the cap has been replaced with a protective screen covering. Employee #6 received one on one re-education relative to proper hand washing technique, with return demonstration, at the time of occurrence. The lime build up on the dish machine and on the floor beneath the clean side of the dish machine has been removed.</p> <p>II. All residents have the potential to be affected, thus, this plan of correction applies to all residents currently residing in the nursing center.</p> <p>III. Nutrition services staff has received re-education relative to storing, preparing, distributing, and serving food under sanitary conditions,</p>	06/20/2012			

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	<p>During a kitchen observation 6/1/12 at 11:17 a.m. Dietary employee #6 was observed washing her hands. She turned off the faucets with her wet hands prior to drying them with paper towels. She donned gloves, took the temperatures of the food on the steamtable and began plating the serving of the food</p> <p>During this observation the dishmachine was observed. The dish machine had a build up of lime on outside of the machine. Dietary staff #7 indicated the machine needed to be delimed. She indicated it is usually done on a weekly basis. There was also white lime build up on the floor beneath the clean side of the dishmachine. The five hood vents had the black residue build up on them.</p> <p>Review of the kitchen cleaning schedules were provided by the CDM on 6/5/12 at 7:57 a.m., and indicated the dishmachine had been delimed on 5/25/12.</p> <p>Review of the 4/28/07, "Handwashing" policy was provided by the Director of Nursing on 6/5/12 at 9:55 a.m. She indicated the policy was for all departments. The policy</p>		<p>including but not limited to, cleaning schedules, potential hazards related to uncovered drains, and proper hand washing technique. Additionally, nutrition services staff have completed return demonstration of proper hand washing technique.</p> <p>IV. A performance improvement tool has been developed that ED, or designee, will utilize to monitor weekly that food is stored, prepared, distributed, and served under sanitary conditions; and that nutrition services staff are utilizing proper hand washing technique. Any concerns will be promptly addressed with responsible individuals.</p> <p>ED, or designee, will review findings weekly and report to PI committee monthly for 6 months to determine need for continued monitoring thereafter.</p> <p>V. Completion Date: June 20, 2012</p>		

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	indicated hands were to be dried first and the faucets were to be turned off with paper towels. 3.1-21(i)(1)				

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE 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 the physician's instructions and an assessment of a resident with a "High" glucometer reading were documented for 1 of 10 residents reviewed for unnecessary medications. (Resident #192)</p> <p>The clinical record for Resident #192 was reviewed on 6/1/12 at 12:53 p.m.</p> <p>Resident #192's current diagnoses included, but were not limited to, diabetes mellitus, hypertension and dementia.</p> <p>A recapitulation of physician's orders for Resident #192, dated 6/1/12, included the following:</p>	F0514	<p>I. Resident #192's glucometer record was reviewed and MD was notified of concern. No new orders or follow-up orders were received. DNS/designee completed individual performance improvement counseling and re-education with the nurse responsible. II. Administrative Nursing/designee completed audits for all residents with glucometer orders. No concerns were identified. III. Nursing staff have been re-educated on accurate documentation, including but not limited to, existing blood sugar (BS) MD notification policy and procedure and the newly implemented BS MD notification process. IV. A performance improvement tool, "BS MD Notification" was implemented for use by Nursing Administration, or designee, to monitor for correct BS MD notification. The B.S.</p>	06/20/2012	

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	<p>A. Monitor blood glucose levels before meals and at bedtime: 6:00 a.m., 11:00 a.m., 4:00 p.m. and 9:00 p.m.</p> <p>B. Administer Novolog sliding scale insulin coverage based on blood glucose results according to the scale below,</p> <p>201 - 250 = 2 units 251 - 300 = 4 units 301 - 350 = 6 units 351 - 450 = 8 units 451 - 500 = 10 units</p> <p>Call physician if blood sugar greater than 500 or if blood sugar less than 60 call physician and use hypoglycemia protocol</p> <p>A health care plan, dated 3/12/12 indicated Resident #192 had a problem listed as, the need to monitor the endocrine system related to diabetes mellitus. Interventions for this problem included, monitor blood sugars as ordered, administer medication as ordered, and monitor for signs and symptoms of hypoglycemia or hyperglycemia.</p> <p>Review of the May Diabetic Monitoring Flow Sheet indicated</p>		<p>-M.D.notification monitoring shall be conducted daily, on scheduled days of work, and will be ongoing to ensure compliance. The DNS, or designee, will review findings weekly and shall report to PI committee monthly for 6 months to determine need for continued monitoring thereafter. V. Completion Date: June 20, 2012</p>				

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	<p>glucometer results on 5/10/12 were "High". The check box for physician notification had been checked.</p> <p>Review of the clinical record lacked any documentation of a repeat glucometer test after the "High" result.</p> <p>Review of the clinical record for 5/10/12 lacked any documentation of physician instructions and/or assessments following his notification of the "High" result. The clinical record lacked any further assessment of the resident prior to the next scheduled glucometer check.</p> <p>During an interview with Staff Nurse #2, on 6/5/12 at 11:41 a.m., she indicated she did speak with the physician on 5/10/12 and failed to document the conversation in the nursing notes. Staff Nurse #2 also indicated she had checked the resident several times after the "High" reading was obtained, but had failed to document her assessments in the clinical record.</p> <p>Review of the current facility policy, dated 9/10, titled "Blood Glucose Monitoring," provided by the Director of Nursing on 6/5/12 at 11:29 p.m., included, but was not limited to, the following:</p>			

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	<p>"Rationale: Blood glucose tells what the blood glucose level is at any given time and is the main tool to monitor diabetes control....</p> <p>...Hyperglycemia 26. If the patient blood sugar results are over 300 mg/dl or registers as HI/High, treat per physician's orders. If the patient is not exhibiting symptoms of hyperglycemia retest to validate results using another meter and new strip....</p> <p>...Documentation Guidelines... ...4.... ...a. Date and time of physician notification, response and new orders if applicable. b. Nursing interventions..."</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				