

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155231	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/04/2013
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NAME OF PROVIDER OR SUPPLIER RANDOLPH NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 701 S OAK ST WINCHESTER, IN 47394
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: August 27, 28, 29, 30, September 3 and 4, 2013</p> <p>Facility Number: 000136 Provider Number: 155231 AIM Number: 100275450</p> <p>Survey Team: Karen Lewis, RN,TC Ginger McNamee, RN Tina Smith-Staats, RN Jason Mench, RN (September 3 and 4, 2013)</p> <p>Census Bed Type: SNF/NF: 60 Total: 60</p> <p>Census Payor Type: Medicare: 7 Medicaid: 43 Other: 10 Total: 60</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>The Plan of Correction is our credible allegation of compliance.Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement of the facts alleged or conclusions set forth in this statement of deficiencies. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. The plan of correction and specific corrective actions are prepared and/or executed in compliance with the state and federal laws. Please accept this plan of correction as it constitutes our credible allegation of compliance with all regulatory requirements.Randolph Nursing Home is requesting desk review for the four (4) citations.</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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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to timely notify a resident's family of a fall for 1 of 4 residents reviewed for falls. (Resident # 3)</p>	F000157	F157, This facility informs the resident, consults with the resident's physician and if known, notifies the resident's legal representative or and interested family member when there is an	10/04/2013

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	<p>Findings include:</p> <p>Resident #3's clinical record was reviewed on 8/30/13 at 10:02 a.m. The resident's diagnoses included, but were not limited to, dementia, osteoarthritis, rheumatoid arthritis, osteoporosis, hypertension, anemia, and anxiety.</p> <p>Review of a 7/31/13, 4:30 p.m., Nurse's Note indicated the resident had fallen and sustained an abrasion to her right knee. The note indicated the Director of Nursing and the Medical Doctor were notified. The note lacked an indication of the family being notified.</p> <p>A 8/1/13, 8:00 a.m., Nurse's Note indicated "Family notified of fall on 7/31/13." The note lacked an indication of who was notified or the time of the notification.</p> <p>The Investigation Report for 7/31/13 at 4:30 p.m., had a check mark in the space for name of the family member called and the spaces for the time notified and relationship were blank.</p> <p>During an interview with the resident's son [health care representative] on 9/3/13 at 1:39 p.m., he indicated the</p>		<p>accident involving the resident with the potential for significant change in condition or change in treatment. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Director of Nursing Service assured the POA for resident #3 was notified of 7/31/13 fall event. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Accidents involving a resident are reviewed during the morning management team meeting to assure appropriate notification of the resident's legal representative or an interested family member. Additionally, on weekends, the nurse manager on duty will review accidents involving a resident to assure appropriate notification of the resident's legal representative or an interested family member and will immediately attempt notification if not previously notified of the event. The nurse involved in the July 31, 2013 event was re-educated regarding appropriate notification of the resident's legal representative or an interested family member. Attachment "G"3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Re-education of licensed nursing staff will be</p>				

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	<p>resident had fallen on 7/31/13 and he had not been called.</p> <p>During an interview with the Director of Nursing on 9/4/13 at 10:01 a.m., she indicated she had called the nurse on duty on 7/31/13, and the nurse told the Director of Nursing the family had not been called at the time of the fall.</p> <p>The 4/30/13, "Change of Condition" policy was provided by the Administrator on 9/4/13 at 2:36 p.m. The policy indicated "...Procedure: 1. Assess resident's condition:...checks for injuries such as falls,....3. Notify resident's designated family/legal representative of condition change...."</p> <p>3.1-5(a)(2)</p>		<p>conducted on September 17, 2013 with review of the policy and procedure for notification of resident changes in condition including appropriate notification of the resident's legal representative or an interested family member. Attachment "F"4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:All resident accident events will be audited during clinical morning meeting to assure notification of the resident's designated individual. This audit will be ongoing for six (6) months with results presented to the facility quality assurance committee monthly. Attachment "A"</p>		

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F000333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on observation, record review and interview, the facility failed to ensure food was served timely after sliding scale insulin administration for 1 of 7 residents observed during medication administration observation and for 1 of 4 residents reviewed for sliding scale insulin coverage as ordered by the physician. (Resident #59)</p> <p>Findings include:</p> <p>1. During a medication administration observation on 8/29/13 at 11:14 a.m., Resident #59 was given a subcutaneous injection of 6 units of Novolog insulin (rapid acting insulin to lower blood sugar levels) by RN #1. Resident #59 was then seated in the dining room and served lunch at 11:58 a.m., 44 minutes after receiving the insulin injection.</p> <p>Manufacturer's directions from the "2010 Nursing Spectrum Drug Handbook," included but were not limited to: "Give by subcutaneous route only, 5 to 10 minutes before a meal."</p>	F000333	<p>F333, This facility strives to assure residents are free of any significant medication error. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The Physician for Resident #59 was notified and the order was clarified to ensure the resident receives the appropriate dose of insulin on 9/6/13. Attachment "B"2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The medication administration records (MAR) for all residents will be reviewed on 9/18/13 to identify any insulin sliding scale orders needing clarification. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: An in-service will be conducted on September 17, 2013 for all RNs and LPNs with education on sliding scale insulin administration, physician's order review, and dose calculation. Non-compliance with facility policy and procedure may result in employee reeducation and/or disciplinary action up to and including termination. Attachment</p>	10/04/2013

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	<p>2. During an observation on 9/3/13 at 10:53 a.m., LPN #1 entered Resident #59's room with a syringe.</p> <p>During an interview on 9/3/13 at 10:59 a.m., LPN #1 indicated she had given Resident #59 6 units of Novolog sliding scale insulin.</p> <p>During an observation on 9/3/13 at 11: 56 a.m., Resident #59 was in the main dining room and served lunch, 57 minutes after receiving the insulin injection.</p> <p>During an interview on 9/3/13 at 10:48 a.m., the Assistant Director of Nursing indicated the glucometers and the sliding scale insulin injections were administered at 11:00 a.m.</p> <p>During an interview on 9/4/13 at 9:51 a.m., the Dietary Manager indicated the service of the mid-day meal in the main dining room begins at noon.</p> <p>3. The clinical record for Resident #59 was reviewed on 9/4/13 at 1:30 p.m.</p> <p>Diagnoses for Resident #59 included, but were not limited to, diabetes mellitus, hypertension, and hyperlipidemia.</p>		"F"4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The DON or designee will audit all sliding scale insulin orders utilizing the medication pass observation tool weekly times 6 months to monitor compliance with medication administration with results to Quality Assurance Committee monthly. If the threshold for compliance of 100% is not met, an action plan will be developed and monitoring will continue until 100% compliance is maintained for 3 months even if the initial 6 month monitoring period is exceeded. Attachment "C"		

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	<p>Current insulin sliding scale physician's orders for Resident #59 included, but were not limited to, the following orders:</p> <p>a.) Check and record blood sugar before meals and at bedtime. The original date of this order was 6/15/13.</p> <p>b.) Novolog (insulin) inject subcutaneous per sliding scale: 141-180 = 1 unit 181-220 = 2 units 221-260 = 4 units 261-300 = 6 units 301-340 = 7 units 341-380 = 8 units 381-420 = 9 units 421- 460 = 10 units greater than 460 = 12 units at bedtime give half coverage The original date of this order was 6/15/13.</p> <p>Review of the June and July 2013 Medication Administration Records (MAR) indicated the resident received the incorrect dose of insulin on the following dates and times:</p> <p>June 3 at 8:00 p.m., the blood sugar result was 265, 6 units of insulin was documented as having been given, the resident should have received 3</p>						

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	<p>units of insulin.</p> <p>June 4 at 8:00 p.m., the blood sugar result was 409, 5 units of insulin was documented as having been given, the resident should have received one-half of 9 units of insulin.</p> <p>June 6 at 8:00 p.m., the blood sugar result was 413, 4 units of insulin was documented as having been given, the resident should have received one-half of 9 units of insulin.</p> <p>June 8 at 8:00 p.m., the blood sugar result was 295, 6 units of insulin was documented as having been given, the resident should have received 3 units of insulin.</p> <p>June 9 at 8:00 p.m., the blood sugar result was 333, 3 units of insulin was documented as having been given, the resident should have received one-half of 7 units of insulin.</p> <p>June 10 at 8:00 p.m., the blood sugar result was 313, 3 units of insulin was documented as having been given, the resident should have received one-half of 7 units of insulin.</p> <p>June 12 at 8:00 p.m., the blood sugar result was 330, 3 units of insulin was documented as having been given,</p>						

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	<p>the resident should have received one-half of 7 units of insulin.</p> <p>June 14 at 8:00 p.m., the blood sugar result was 263, 6 units of insulin was documented as having been given, the resident should have received 3 units of insulin.</p> <p>June 16 at 8:00 p.m., the blood sugar result was 309, 3 units of insulin was documented as having been given, the resident should have received one-half of 7 units of insulin.</p> <p>June 17 at 8:00 p.m., the blood sugar result was 396, 4 units of insulin was documented as having been given, the resident should have received one-half of 9 units of insulin.</p> <p>June 21 at 8:00 p.m., the blood sugar result was 415, 5 units of insulin was documented as having been given, the resident should have received one-half of 9 units of insulin.</p> <p>June 22 at 8:00 p.m., the blood sugar result was 351, 8 units of insulin was documented as having been given, the resident should have received 4 units of insulin.</p> <p>June 23 at 8:00 p.m., the blood sugar result was 316, 3 units of insulin was</p>			

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	<p>documented as having been given, the resident should have received one-half of 7 units of insulin.</p> <p>June 24 at 8:00 p.m., the blood sugar result was 392, 9 units of insulin was documented as having been given, the resident should have received one-half of 9 units of insulin.</p> <p>June 28 at 8:00 p.m., the blood sugar result was 335, 3 units of insulin was documented as having been given, the resident should have received one-half of 7 units of insulin.</p> <p>June 29 at 8:00 p.m., the blood sugar result was 308, 3 units of insulin was documented as having been given, the resident should have received one-half of 7 units of insulin.</p> <p>June 30 at 8:00 p.m., the blood sugar result was 333, 3 units of insulin was documented as having been given, the resident should have received one-half of 7 units of insulin.</p> <p>This resulted in the resident receiving the wrong dose of sliding scale insulin 17 times in June, 2013.</p> <p>July 2 at 8:00 p.m., the blood sugar result was 303, 7 units of insulin was documented as having been given,</p>			

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	<p>the resident should have received one-half of 7 units of insulin.</p> <p>July 3 at 8:00 p.m., the blood sugar result was 316, 4 units of insulin was documented as having been given, the resident should have received one-half of 7 units of insulin.</p> <p>July 4 at 8:00 p.m., the blood sugar result was 326, 4 units of insulin was documented as having been given, the resident should have received one-half of 7 units of insulin.</p> <p>July 8 at 8:00 p.m., the blood sugar result was 275, 6 units of insulin was documented as having been given, the resident should have received 3 units of insulin.</p> <p>July 9 at 8:00 p.m., the blood sugar result was 235, 4 units of insulin was documented as having been given, the resident should have received 2 units of insulin.</p> <p>July 11 at 8:00 p.m., the blood sugar result was 347, 8 units of insulin was documented as having been given, the resident should have received 4 units of insulin.</p> <p>July 12 at 8:00 p.m., the blood sugar result was 352, 8 units of insulin was</p>			

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	<p>documented as having been given, the resident should have received 4 units of insulin.</p> <p>July 16 at 8:00 p.m., the blood sugar result was 328, 7 units of insulin was documented as having been given, the resident should have received one-half of 7 units of insulin.</p> <p>July 20 at 8:00 p.m., the blood sugar result was 264, 6 units of insulin was documented as having been given, the resident should have received 3 units of insulin.</p> <p>July 23 at 8:00 p.m., the blood sugar result was 308, 3 units of insulin was documented as having been given, the resident should have received one-half of 7 units of insulin.</p> <p>This resulted in the resident receiving the wrong dose of sliding scale insulin 10 times in July, 2013.</p> <p>During an interview with the Director of Nursing on 9/4/13 at 1:44 p.m., additional information related to the incorrect insulin coverage at bedtime was requested.</p> <p>The facility failed to provide any additional information as of exit on 9/4/13.</p>			

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	<p>Review of the current facility policy, dated 9/05, titled "INJECTIONS, INSULIN," provided by the Assistant Director of Nursing on 9/4/13 at 3:18 p.m., included, but was not limited to, the following:</p> <p>"PURPOSE: Insulin is injected to aid oxidation and utilization of blood sugar by the tissues, and to control blood sugar levels in residents with Diabetes Mellitus....</p> <p>...PREPARING THE INSULIN: 1. Check the physician's order..."</p> <p>3.1-48(c)(2) 3.1-37(a)</p>			

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F000428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on interview and record review, the facility failed to ensure the Consultant Pharmacist reviewed medication orders to ensure directions were clear to understand for 1 of 4 residents reviewed for insulin administration. (Resident #59)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #59 was reviewed on 9/4/13 at 1:30 p.m.</p> <p>Diagnoses for Resident #59 included, but were not limited to, diabetes mellitus, hypertension, and hyperlipidemia.</p> <p>Current insulin sliding scale physician's orders for Resident #59 included, but were not limited to, the following orders:</p> <p>a.) Check and record blood sugar before meals and at bedtime. The</p>	F000428	F428, The drug regimen of each resident must be reviewed at least once a month by a registered pharmacist.1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:The physician for Resident #59 was notified on 9/6/13 and the order was clarified to ensure the resident receives the appropriate dose of insulin. The consultant pharmacist was notified on 9/4/13 of the necessity of review of medication orders to ensure the directions are clear to understand.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:The consultant pharmacist will review all resident's MARs, on 9/18/13 to ensure medication orders were written according to current standards of practice and directions are clear to understand.3. What measures will be put into place or what systemic changes will be made to	10/04/2013	

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	<p>original date of this order was 6/15/13.</p> <p>b.) Novolog (insulin) inject subcutaneous per sliding scale: 141-180 = 1 unit 181-220 =2 units 221-260 = 4 units 261-300 = 6 units 301-340 = 7 units 241-380 = 8 units 381-420 = 9 units 421- 460 = 10 units greater than 460 = 12 units at bedtime give half coverage The original date of this order was 6/15/13.</p> <p>The clinical record indicated the pharmacist reviewed the physician's orders in June, July, and August of 2013. No recommendations were made related to the insulin sliding scale half coverage at bedtime orders.</p> <p>During an interview with the Assistant Director of Nursing on 9/4/13 at 2:33 p.m., additional information was requested related to the pharmacy consultant's reports and lack of recommendations related to the incorrect insulin coverage at bedtime.</p> <p>During an interview with the Assistant</p>		<p>ensure that the deficient practice does not recur:An in-service for all RNs and LPNs will be conducted on September 17, 2013 with education regarding notification of the physician for medication order clarification. An audit of new insulin orders will be completed through the morning meeting process to assure all new orders are written with clear directions. The consultant pharmacist and physician will be notified as indicated regarding the necessity to clarify directions for insulin administration. Attachment "F"4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;The nurse assigned to review monthly physician order recapitulation/rewrites will ensure the direction of medication orders are clear to understand and obtain clarification if needed. All new orders will be reviewed by the Interdisciplinary Team in clinical morning meeting Monday through Friday for direction for medication administration. A consultant pharmacist review tool will be utilized daily for 6 months with results presented to the facility Quality Assurance Committee monthly. Attachment "D"</p>				

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	<p>Director of Nursing on 9/4/13 at 3:16 p.m., she indicated there were no recommendations from the pharmacy reviews for the insulin sliding scale half coverage at bedtime orders.</p> <p>3.1-25(i)</p>				

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F000520 SS=D	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, interview and record review, the facility failed to identify and put in place an action plan to address the amount of time between the injection of insulin and meal time for 1 of 4 residents who used sliding scale insulin coverage. (Resident #59)</p> <p>Findings include:</p> <p>1. During a medication administration observation on 8/29/13 at 11:14 a.m.,</p>	F000520	F520, This facility maintains a quality assessment and assurance committee consisting of the director of nursing service, a physician, and at least three other members of the facility staff. This committee meets at least quarterly.1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:Resident #59's MAR was changed to reflect appropriate time to administer insulin prior to meals and the Physician and	10/04/2013

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	<p>Resident #59 was given a subcutaneous injection of 6 units of Novolog insulin (rapid acting insulin to lower blood sugar levels) by RN #1. Resident #59 was then seated in the dining room and served lunch at 11:58 a.m., 44 minutes after receiving the insulin injection.</p> <p>Manufacturer's directions from the "2010 Nursing Spectrum Drug Handbook," included but were not limited to: "Give by subcutaneous route only, 5 to 10 minutes before a meal."</p> <p>2. During an observation on 9/3/13 at 10:53 a.m., LPN #1 entered resident #59's room with a syringe.</p> <p>During an interview on 9/3/13 at 10:59 a.m., LPN #1 indicated she had given resident #59 6 units of Novolog Sliding scale insulin.</p> <p>During an interview on 9/3/13 at 10:48 a.m., the Assistant Director of Nursing indicated the glucometers and the sliding scale insulin injections were administered at 11:00 a.m.</p> <p>During an interview on 9/4/13 at 9:51 a.m., the Dietary Manager indicated the service of the mid-day meal in the main dining room begins at noon.</p>		<p>POA were notified.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:The MARs for all residents receiving insulin were reviewed and revised as necessary to reflect appropriate time for insulin administration prior to meals. Attachment "H"3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:An in-service for all RNs and LPNs will be conducted on 9/17/13, including review of the insulin administration policy as well appropriate times to administer insulin prior to meals. Attachment "F"4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:An action plan was initiated regarding monitoring for correct insulin administration times in relation to meal. A medication pass observation tool will be utilized weekly for 4 weeks than monthly for 5 months to monitor compliance with insulin administration. Results of the insulin administration audit will be presented to the facility Quality Assurance Committee monthly. Attachment "E"</p>		

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	<p>During an interview on 9/4/13 at 4:00 p.m., with the Director of Nursing, she indicated the facility had not identified concerns with the relationship between the administration of insulin and meals being served.</p> <p>3.1-52(b)(2)</p>			