STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155139	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH WOODS VILLAGE	2233 W JEFFERSON ST KOKOMO, IN 46901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for the Investigation of Complaint # IN00137799. Complaint # IN00137799-Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F246, F279, and F282. . Survey dates: October 15, 16 & 17, 2013 Facility number: 000064 Provider number: 155139 AIM number: 100288770 Survey team: Michelle Carter, RN Census bed type: SNF: 16 SNF/NF: 132 Total: 148 Census payor type: Medicare: 23 Medicaid: 98 Other: 27 Total: 148 Sample: 6	F000000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and respectfully requests Desk Review in lieu of Post Survey Review on or after 11-1-13.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality Review was completed by Tammy Alley RN on October 21, 2013.			

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NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901	

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F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on record review and interview, the facility failed to notify the physician regarding an elevated blood glucose number for 1 of 4 diabetic residents reviewed for	F000157	F157 Notify of Changes It is the practice of this provider to immediately inform the resident, consult with the resident's physician, and if known, notify the resident's legal representative or	11/01/2013

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	physician notification, in a sample of 6. (Resident B) Findings include: The record for Resident B was reviewed on 10/15/13 at 1:30 p.m. Diagnoses for Resident B included, but were not limited to, diabetes mellitus- type 2, peripheral neuropathy, high blood pressure, dysphagia, osteoarthritis, depressive disorder, status post cerebrovascular accident, and left side hemiplegia. A physician order, dated 10/8/13, stated Novolog (fast acting insulin) solution, amount to administer; per sliding scale; subcutaneous (injection), 4 times per day. The sliding scale, listed under special instructions, was as follows: Blood glucose # (Novolog) to administer: Units 0 - 60 call MD 61-150 0 units 151 - 200 2 units 201 - 250 4 units 251 - 300 6 units 301 - 350 8 units 351 - 400 10 units 401 or greater call MD		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; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident B:Resident's sliding scale instructions for insulin and protocol reviewed for following protocol with resident preference, administering and documenting insulin per physician orders and physician notification if change in condition.Licensed nurses were re-educated to the facility's policy on Accu-check (blood glucose monitor), Sliding scale insulin monitoring protocol with resident preferences, administration, documentation per physician orders Change of Condition Policy and Procedure (notification of physician) by 10-29-13 by the Staff Development Coordinator (SDC)/Designee. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Residents who experience a change of condition with blood glucose monitoring and sliding scale insulin have the potential to	

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	A nurses note, dated 10/3/13, at 7:45 a.m., indicated the following, "Accu check [blood glucose monitor] 49. Resident refused orange juice. Bolus of Jevity given. Routine short acting insulin was held. Resident was alert and talking to writer." A nurses note, dated 10/5/13, at 6:21 a.m., indicated the resident requested a blood glucose check at 4:45 a.m. Results were 46. At 5:15 a.m., Resident B's blood glucose was checked again, results were 58. A nurses note, dated 10/8/13 at 7:00 a.m., indicated, "Resident resting in bed. .....Blood sugar [glucose] 51 at this time. Will treat and recheck." During an interview with the DoN, on 10/16/13 at 10:40 a.m., she indicated the physician should have been notified of a blood glucose level of 60 or less, per physician orders. Documentation provided did not indicate physician notification on 10/3, 10/5, and 10/8/13. This Federal tag relates to complaint IN00137799. 3.1-5(a)(2)		be affected by the alleged deficient practice.Licensed nurses were re-educated to the facility's policy on Accu-check (blood glucose monitor), Sliding scale insulin monitoring protocol with resident preferences, administration, documentation per physician ordersChange of Condition Policy and Procedure (notification of physician) by 10-29-13 by the Staff Development Coordinator (SDC)/Designee. Residents with Blood glucose monitoring and sliding scale insulin were reviewed to ensure protocol followed per physician orders, resident preference and timely notification of physician was documented. Noncompliance with facility policy and procedure may result in employeedisciplinary action up to and including termination. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur Resident 's Diabetic Flow Sheets are reviewed for compliance and resident preferences daily Monday thru Friday by Director of Nursing Services (DNS) or Designee and Weekend nurse manager Saturday and Sunday to ensure compliance is met.Medication Administration Audit will be completed by DNS/Designee to ensure Physicians orders are followed and correct amount of Insulin is administered when	

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			residents have sliding scaleNoncompliance with facility policy and procedure may result in employee disciplinary action up to and including termination. Licensed nurses were re-educated to the facility's policy on Accu-check (blood glucose monitor), Sliding scale insulin monitoring protocol with resident preferences, administration, documentation per physician ordersChange of Condition Policy and Procedure (notification of physician) by 10-29-13 by the Staff Development Coordinator (SDC)/Designee. 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 DNS/Designee will monitor Diabetic Flow sheet ensure resident with sliding scale has orders and protocol followed and change of condition is reported to the physician, as required by order or protocol.CQI "Blood Glucose Machines and testing/accuchecks" tool will be utilized weekly x 4, monthly x 2, and quarterly, thereafter for at least six months, to monitor physician notification compliance. The data will be submitted to the CQI committee for review and follow up.An action plan will be developed for identified issues if 90%threshold not met. Compliance date: 11-1-13	

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F000246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.			
	Based on record review and interview, the facility failed to assess for preferences related to treatment of a hypoglycemic event, for 1 of 4 diabetic residents reviewed for preferences, in a sample of 6. (Resident B) Findings include: The record for Resident B was reviewed on 10/15/13 at 1:30 p.m. Diagnoses for Resident B included, but were not limited to, diabetes mellitus- type 2, peripheral neuropathy, high blood pressure, dysphagia, osteoarthritis, depressive disorder, status post cerebrovascular accident, and left side hemiplegia. During an interview with Resident B, on 10/15/13 at 2:50 p.m., Resident B indicated a strong dislike for orange juice and apple juice. He indicated he was offered orange juice to treat a low blood sugar (glucose) level, even	F000246	F246 Reasonable Accommodation of Needs/Preferences It is the practice of this provider to ensure the residents receives services in this facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident B with Accu-check and sliding scale for insulin, care plan has been reviewed and updated to reflect current status and preferences.Resident prefers Chocolate Milk.Licensed nurses were re-educated to the facility's policy on Accu-check (blood glucose monitor), Sliding scale insulin monitoring protocol with resident preferences, administration, documentation per physician ordersChange of Condition Policy and Procedure (notification of physician) by 10-29-13 by the Staff Development Coordinator (SDC)/Designee. How will you	11/01/2013

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	though he voiced his dislike of orange juice. Nurses notes, dated 10/3, 10/5, and 10/11/13, indicated Resident B did not like orange juice and would not accept orange juice as a treatment for a low blood glucose level. A care plan for Resident B and treatment of a low blood glucose event was not provided by the facility. During an interview with the DoN, on 10/16/13 at 9:40 a.m., she indicated the facility did not have a hypoglycemic care plan/protocol developed with Resident B's personal preferences. The nursing staff followed a standing hypoglycemic protocol/order. This Federal tag relates to complaint IN00137799. 3.1-3(v)(1)		identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Licensed nurses were re-educated to the facility's policy on Accu-check (blood glucose monitor), Sliding scale insulin monitoring protocol with resident preferences, administration, documentation per physician ordersChange of Condition Policy and Procedure (notification of physician) by 10-29-13 by the Staff Development Coordinator (SDC)/Designee. All resident's who need a Care Plan developed or a revision to their care plan withaccu-check and sliding scale for insulin have the potential to be affected by the alleged deficient practice.Residents with Blood glucose monitoring and sliding scale insulin were reviewed to ensure protocol followed per physician orders with proper administration and documentation and resident preferences and timely notification of physician was documented and care plan developed. Noncompliance with facility policy and procedure may result in employee re-education, and/or disciplinary action up to and including termination. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur Residents comprehensive care plans will be developed upon admission and reviewed at least	

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			quarterly by the IDT and updated as neededand to include resident preferences. Licensed nurses were re-educated to the facility's policy on Accu-check (blood glucose monitor), Sliding scale insulin monitoring protocol with resident preferences, administration, documentation per physician ordersChange of Condition Policy and Procedure (notification of physician) by 10-29-13 by the Staff Development Coordinator (SDC)/Designee. The MDS Coordinator and IDT is responsible to ensure resident's plan of care is an accurate reflection of residents needs. 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 DNS/Designee will monitor Diabetic Flow sheet ensure resident with sliding scale has orders and protocol followed and change of condition is reported to the physician, as required by order or protocol.CQI "Blood Glucose Machines and testing/accuchecks" tool will be utilized weekly x 4, monthly x 2, and quarterly, thereafter for at least six months, to monitor physician notification compliance. The CQI committee will review the data. If the threshold of 90% for compliance is not met, an action plan will be developed. Compliance date: 11-1-13	

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F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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).			
	Based on record review and interview, the facility failed to develop a personalized care plan for treatment related to the event of a hypoglycemic episode, for 1 of 4 diabetic residents reviewed for preferences, in a sample of 6. (Resident B) Findings include: The record for Resident B was reviewed on 10/15/13 at 1:30 p.m. Diagnoses for Resident B included, but were not limited to, diabetes	F000279	F279 Develop Comprehensive Care Plans It is the practice of this provider to develop, review and revise the resident's comprehensive plan of care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident B with Accu-check and sliding scale for insulin, care plan has been reviewed and updated to reflect current status and preferences.Resident prefers Chocolate Milk. Licensed nurses were re-educated to the facility's policy on Accu-check (blood glucose monitor), Sliding scale	11/01/2013

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	mellitus- type 2, peripheral neuropathy, high blood pressure, dysphagia, osteoarthritis, depressive disorder, status post cerebrovascular accident, and left side hemiplegia. During an interview with Resident B, on 10/15/13 at 2:50 p.m., Resident B indicated a strong dislike for orange juice and apple juice. He indicated he was offered orange juice to treat a low blood sugar (glucose) level, even though he voiced his dislike of orange juice. Nurses notes, dated 10/3, 10/5, and 10/11/13, indicated Resident B did not like orange juice and would not accept orange juice as a treatment for a low blood glucose level. A care plan for Resident B and treatment of a low blood glucose event was not provided by the facility. During an interview with the DoN, on 10/16/13 at 9:40 a.m., she indicated the facility did not have a hypoglycemic care plan/protocol developed with Resident B's personal preferences. The nursing staff followed a standing hypoglycemic protocol/order. This Federal tag relates to complaint IN00137799.		insulin monitoring protocol with resident preferences, administration, documentation per physician ordersChange of Condition Policy and Procedure (notification of physician) by 10-29-13 by the Staff Development Coordinator (SDC)/Designee. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken All resident's who need a Care Plan developed or arevision to their care plan withaccu-check and sliding scale for insulin have the potential to be affected by the alleged deficient practice.Residents with Blood glucose monitoring and sliding scale insulin were reviewed to ensure protocol followed per physician orders with proper administration and documentation and resident preferences and timely notification of physician was documented and care plan developed. Noncompliance with facility policy and procedure may result in employee re-education, and/or disciplinary action up to and including termination. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur Residents comprehensive care plans will be developed upon admission and reviewed at least quarterly by the IDT and updated as neededand to include resident	

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	3.1-35(b)(1)		preferences.The MDS Coordinator and IDT is responsible to ensure resident's plan of care is an accurate reflection of residents needs. 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 DNS/Designee will monitor Diabetic Flow sheet ensure resident with sliding scale has orders and protocol followed and change of condition is reported to the physician, as required by order or protocol.CQI "Blood Glucose Machines and testing/accuchecks" tool will be utilized weekly x 4, monthly x 2, and quarterly, thereafter for at least six months, to monitor physician notification compliance. The CQI committee will review the data. If the threshold of 90% for compliance is not met, an action plan will be developed. Compliance date: 11-1-13	

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			
	Based on record review and interview, the facility failed to follow physicians orders for hypoglycemic (low blood glucose level) protocol and failed to administer the correct amount of insulin for 1 of 4 diabetic residents reviewed for physicians orders in a sample of 6. (Resident B) Findings include: The record for Resident B was reviewed on 10/15/13 at 1:30 p.m. Diagnoses for Resident B included, but were not limited to, diabetes mellitus- type 2, peripheral neuropathy, high blood pressure, dysphagia, osteoarthritis, depressive disorder, status post cerebrovascular accident, and left side hemiplegia. 1. October 2013 nursing notes indicated Resident B had a low blood glucose level on 10/3, 10/4, 10/5, 10/8, 10/9, and 10/11/13, and was treated, as follows: 10/3/13- "Accu check 49. ....Bolus of	F000282	F282 Services By Qualified Persons/per Care Plan It is the practice of this provider to ensure services provided or arranged by this facility must be provided by qualified persons in accordance with each resident's written plan of care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident B with Accu-check and sliding scale for insulin, care plan has been reviewed and updated to reflect current status and preferences.Resident prefers Chocolate Milk. Licensed nurses were re-educated to the facility's policy on Accu-check (blood glucose monitor), Sliding scale insulin monitoring protocol with resident preferences, administration, documentation per physician ordersChange of Condition Policy and Procedure (notification of physician) by 10-29-13 by the Staff Development Coordinator/Designee. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken All resident's who need a	11/01/2013

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NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901	

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	Jevity [nutritional feeding via g-tube] 1.5 given....." 10/4/13- "AM [morning] blood sugar 47. AM blood sugar treated per protocol...." 10/5/13- "...BS [blood sugar] was 46...gave resident PBJ [peanut butter and jelly] and ice cream. At 5:15 BS was checked and was 58...given ice cream and BS was checked again and BS was 67. Res [resident] was given two cookies and carton of milk to raise BS again." 10/8/13- "...Blood sugar 51 at this time. Will treat and recheck." 10/9/13- "Accu check 48. Res ate his oatmeal and Accu check redone and it was 94. MD notified." 10/11/13- "... AM blood sugar 57. 1 mL [milliliter] Glucagon administered per order as resident will not drink orange juice. 15 minutes later, blood sugar 148. [name of doctor] notified and orders received...." The October medication administration record (MAR) indicated a physician's order, dated 10/2/13, as follows: "Hypoglycemic Protocol: Blood glucose 60 or below and resident is able to consume PO (oral) intake: administer 4 ounces of juice and recheck blood glucose in 15 minutes.		Care Plan developed or arevision to their care plan withaccu-check and sliding scale for insulin have the potential to be affected by the alleged deficient practice.Residents with Blood glucose monitoring and sliding scale insulin were reviewed to ensure protocol followed per physician orders with proper administration and documentation and resident preferences and timely notification of physician was documented and care plan developed.Licensed nurses were re-educated to the facility's policy on Accu-check (blood glucose monitor), Sliding scale insulin monitoring protocol with resident preferences, administration, documentation per physician ordersChange of Condition Policy and Procedure (notification of physician) by 10-29-13 by the Staff Development Coordinator (SDC)/Designee. Noncompliance with facility policy and procedure may result in employee re-education, and/or disciplinary action up to and including termination. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recurResidents comprehensive care plans will be developed upon admission and reviewed at least quarterly by the IDT and updated as neededand to include resident preferences.Medication Administration Audit will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155139	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/17/2013
NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN 46901	

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	If symptomatic or if blood glucose is still 60 or less, repeat another 4 ounces of juice. Recheck blood glucose in 15 minutes. If symptomatic or blood glucose is still 60 or less after two treatments, notify physician of resident's status." "Hypoglycemic Protocol: Blood glucose 60 or below and resident is NOT able to consume PO intake: Administer PRN (as needed) glucose (Glucagon) per order. Recheck blood glucose in 15 minutes, document results, assessment, current resident status and MD/family notification. *If there is not a PRN order, notify MD immediately.*" During an interview with the DoN, on 10/16/13 at 1:30 p.m., she indicated the hypoglycemic protocol was not thoroughly followed by nursing staff on the previously mentioned dates. She indicated the hypoglycemic protocol was a standing physician order for the facility. 2. The October 2013 medication administration record (MAR) indicated a physician's order, dated 10/2/13, as follows: Novolog (fast acting insulin) solution, amount to administer; per sliding		completed by DNS/Designee to ensure Physicians orders are followed and correct amount of Insulin is administered when residents have sliding scale Licensed nurses were re-educated to the facility's policy on Accu-check (blood glucose monitor), Sliding scale insulin monitoring protocol with resident preferences, administration, documentation per physician ordersChange of Condition Policy and Procedure (notification of physician) by 10-29-13 by the Staff Development Coordinator (SDC)/Designee. The MDS Coordinator and IDT is responsible to ensure resident's plan of care is an accurate reflection of residents needs. 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 DNS/Designee will monitor Diabetic Flow sheet ensure resident with sliding scale has orders and protocol followed and change of condition is reported to the physician, as required by order or protocol.CQI "Blood Glucose Machines and testing/accuchecks" tool will be utilized weekly x 4, monthly x 2, and quarterly, thereafter for at least six months, to monitor physician notification compliance. The CQI committee will review the data. If the threshold of 90% for compliance is not met, an	

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	scale; subcutaneous (injection), 4 times per day. The sliding scale, listed under special instructions, was as follows: Blood glucose # (Novolog) to administer: Units 0 - 60 call MD 61-150 0 units 151 - 200 2 units 201 - 250 4 units 251 - 300 6 units 301 - 350 8 units 351 - 400 10 units 401 or greater call MD The October 2013 MAR indicated on 10/6/13, at 9:04 p.m., Resident B's blood glucose level was 300. The administrated units indicated Resident B was given 8 units of Novolog insulin. The DoN indicated, during an interview on 10/16/13, at 1:30 p.m., the administered units of Novolog was incorrect, per physician orders. The correct amount of units, that should have been administered, was 6 units. This Federal tag relates to complaint IN00137799.		action plan will be developed. Compliance date: 11-1-13	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH WOODS VILLAGE	2233 W JEFFERSON ST KOKOMO, IN 46901

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