

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/03/2014
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NAME OF PROVIDER OR SUPPLIER WHISPERING PINES REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 TIOGA RD MONTICELLO, IN 47960
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F000000	<p>This visit was for the Investigation of Complaint IN00157082.</p> <p>Complaint IN00157082-Substantiated. Federal/State deficiencies related to the allegations are cited a F157, F282, and F309.</p> <p>Survey Dates: October 3, 2014</p> <p>Facility number: 000216 Provider number: 155323 AIM number: 100267580</p> <p>Survey team: Regina Sanders, RN, TC</p> <p>Census bed type: SNF/NF: 45 Total: 45</p> <p>Census Payor type: Medicare: 6 Medicaid: 33 Other: 6 Total: 45</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000		

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>Quality review completed on October 6, 2014, by Janelyn Kulik, RN.</p> <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</p>			

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	<p>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 notify resident's Physicians of low blood sugars and high blood sugars, for 2 of 3 residents reviewed for blood sugars in a total sample of 3. (Residents #B and #C)</p> <p>Findings include:</p> <p>1. Resident #B's record was reviewed on 10/03/14 at 10:10 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and peripheral vascular disease.</p> <p>The Physician's Recapitulation Orders, dated 10/2014, indicated an order (04/02/13) to check the resident's blood sugar before meals and at bedtime. An order, dated 02/07/14, indicated to notify the Physician for a blood sugar less than 60 or higher than 350.</p> <p>The Blood Glucose Monitoring Record, dated 09/2014, indicated the resident's blood sugar on 09/04/14 at 7 a.m. was 59.</p> <p>There was no documentation in the</p>	F000157	<p>The Physicians, for both Resident #B and #C, were updated on residents blood glucose levels, There were no new orders received pertaining to Resident #B and #C's insulin or glucose monitoring. Resident #B and #C's medical records were reviewed and the physician notified of other (if any) episodes of blood glucose levels that warrant physician notification per ordered hi/low parameters.</p> <p>In effort to identify other residents potentially affected, a medical record review for all residents with a diagnosis of Insulin Dependent Diabetes Mellitus was conducted. No further Residents were identified with glucose levels which warrant physician notification per ordered hi/low parameters. To ensure that the deficient practice does not recur, the facility conducted In-Service training for all licensed nurses on 10-14-2014. The content of the In-Service included information regarding physician notification when a resident has an episode of their blood sugars levels warranting physician notification per ordered hi/low parameters, and/ or the resident is displaying signs and</p>	10/20/2014

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	<p>resident's Nurses' Notes for 09/04/14 to indicate the Physician was notified of the blood sugar less than 60.</p> <p>During an interview on 10/03/14 at 1:20 p.m., the RN Nurse Consultant indicated she could not find information to indicate the Physician was notified of the low blood sugar.</p> <p>2. Resident #C's record was reviewed on 10/03/14 at 9:25 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and hypertension.</p> <p>The Physician's Recapitulation Orders, dated 09/14, indicated an order, dated 04/02/13, to monitor the resident's blood sugar twice a day and an order on 05/26/10 to notify the Physician if the blood sugar was less than 70 or more than 350.</p> <p>The Blood Glucose Monitoring Record, dated 09/2014, indicated the resident's blood sugar on 09/09/14 at 7 a.m. was 53.</p> <p>There was a lack of documentation on 09/09/14 to indicate the Physician was notified of the blood sugar less than 60.</p> <p>The Blood Glucose Monitoring Record, dated 09/2014, indicated the resident's blood sugars on 09/16/14 at 4:30 p.m.</p>		<p>symptoms of blood sugar complications.</p> <p>To monitor the corrective actions, the DON or Designee will be responsible to conduct an audit on 100% of the residents with InsulinDependent Diabetes Mellitus. Through the process of auditing, the Director of Nursing or Designee will ensure that any resident with an occurrence of high or low blood sugars levels which warrant physician notification per ordered hi/low parameters are appropriately assessed and the Physician promptly notified. The Audits will be conducted at a rate of weekly for five weeks and then monthly thereafter. The DON will be responsible to present and review any noted concerns to the Quality Assurance Committee monthly for three months and then quarterly thereafter.</p> <p>All systemic changes will be completed by 10/20/2014.</p>	

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F000282 SS=D	<p>was 352 and 09/17/14 at 7 a.m. was 384.</p> <p>There was a lack of documentation on 09/16/14 and 09/17/14 to indicate the Physician had been notified of the blood sugars more than 350.</p> <p>During an interview on 10/03/14 at 1:20 p.m., the RN Nurse Consultant indicated she could not find information to indicate the resident's Physician had been notified of the blood sugars.</p> <p>An undated, facility policy, titled, "Physician & Family Notification Procedure", received from the Administrator as current on 10/03/14 at 1 p.m., indicated, "...3. Notify the physician of any change in condition that may or may not warrant a change in the treatment plan..."</p> <p>This Federal Tag relates to complaint IN00157082.</p> <p>3.1-5(a)(3)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER</p>			

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	<p>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.</p> <p>Based on record review and interview, the facility failed to follow Physician's orders and care plans, related to high blood sugars (hyperglycemia) and low blood sugars (hypoglycemia) and insulin administration for 3 of 3 residents reviewed for blood sugars in a total sample of 3. (Residents #B, #C, and #D)</p> <p>Findings include:</p> <p>1. Resident #B's record was reviewed on 10/03/14 at 10:10 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and peripheral vascular disease.</p> <p>A Care Plan, dated 08/28/14, indicated the resident had a risk for experiencing hypoglycemia and hyperglycemia due to uncontrolled diabetes mellitus. The interventions included, to observe for signs and symptoms of hypoglycemia, and call the Physician if blood sugar was less than 60 or more than 350.</p> <p>The Physician's Recapitulation Orders, dated 10/2014, indicated an order (04/02/13) to check the resident's blood sugar before meals and at bedtime. An</p>	F000282	Resident #B, #C, and #D Physician were updated on each of the resident's recent glucose levels. There was no new orders received pertaining to the resident's insulin dosages or frequency of accu-checks. The blood glucose monitoring forms have been audited by the Director of Nursing or Designee for resident #B, #C, and #D to ensure that the blood glucose levels have been completed and documented as ordered by the physician, the insulin has been administered as prescribed and documented as completed, and if needed, an assessment completed to further evaluate an episode of high or low blood sugar. In effort to identify other residents potentially affected, a medical record review for all residents with a diagnosis of Insulin Dependent Diabetes Mellitus was conducted. No further Residents were identified to have had glucose levels that warranted physician notification per ordered hi/low parameters. The blood glucose monitoring forms have been audited by the Director of Nursing or Designee for all of the diabetic residents to ensure that the blood glucose levels have been completed and documented as ordered by the physician, the	10/20/2014			

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	<p>order, dated 02/07/14, indicated to notify the Physician for a blood sugar less than 60 or higher than 350.</p> <p>The Blood Glucose Monitoring Record, dated 09/2014, indicated the resident's blood sugar on 09/04/14 at 7 a.m. was 59 and a snack was given.</p> <p>There was no documentation in the resident's Nurses' Notes for 09/04/14 to indicate an assessment for the low blood sugar had been completed and the Physician was notified.</p> <p>During an interview on 10/03/14 at 1:20 p.m., the RN Nurse Consultant indicated she could not find supportive documentation the resident was assessed for hypoglycemia and the Physician was notified of the low blood sugar.</p> <p>2. Resident #C's record was reviewed on 10/03/14 at 9:25 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and hypertension.</p> <p>A care plan, dated 06/05/14 and 09/06/14, indicated the resident was at risk for experiencing hypoglycemia and hyperglycemia related to diabetes mellitus. The interventions included to observe for signs of symptoms of hypoglycemia and hyperglycemia and</p>		<p>insulin has been administered as prescribed and documented as completed, and if needed, an assessment completed to further evaluate an episode of high or low blood sugar which warrant physician notification per ordered hi/low parameters. There were no further Resident identified of having blood glucose levels that warrant physician notification per ordered hi/low parameters, and/or Residents having blood glucose complications.</p> <p>To ensure that the deficient practice does not recur the facility conducted In-Service training for the licensed nurses on 10-14-2014. The content of the In-Service included information regarding following: physician orders precisely, insulin administration, and conducting assessments for residents that have blood sugar events and /or their glucose levels warrant physician notification per ordered hi/low parameters.</p> <p>To monitor the corrective actions, the DON or Designee will be responsible to conduct an audit on 100% of the residents with Insulin Dependent Diabetes Mellitus. Through the process of auditing, the Director of Nursing or Designee will ensure that any resident with an occurrence of blood glucose levels that warrant physician notification per ordered hi/low parameters are appropriately assessed and the Physician promptly</p>				

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	<p>insulin as ordered.</p> <p>The Physician's Recapitulation Orders, dated 09/2014, indicated an order, dated 04/02/13, to monitor the resident's blood sugar twice a day and an order on 05/26/10 to notify the Physician if the blood sugar was less than 70 or more than 350. An order dated 03/19/14 indicated to give Novolin insulin on a sliding scale (insulin amount given by blood sugar level). The sliding scale order was as follows: Novolin sliding scale at 8 a.m. was blood sugar of 70-109- 3 unit and blood sugar over 110-give 6 units. The Novolin sliding scale at 5 p.m. was blood sugar 70-109- 4 units and blood sugar over 110- give 8 units of insulin.</p> <p>The Blood Glucose Monitoring Record, dated 09/2014, indicated the resident's blood sugar on 09/09/14 at 7 a.m. was 53.</p> <p>There was a lack of documentation on 09/09/14 to indicate the resident's Physician was notified of the blood sugar below 60.</p> <p>The Blood Glucose Monitoring Record, dated 09/2014, indicated the resident's blood sugars on 09/16/14 at 4:30 p.m. was 352 and 09/17/14 at 7 a.m. was 384 and eight units of Novolin insulin was</p>		<p>notified, the accu-checks arecompleted as ordered, and the insulin administered as prescribed . The Auditswill be conducted at a rate of weekly for five weeks and then monthlythereafter. The DON will be responsible to present and review any noted concernsto the Quality Assurance Committee monthly for three months and then quarterlythereafter. All systemic changes will be completed by 10/20/2014.</p>		

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	<p>given.</p> <p>There was a lack of documentation on 09/16/14 and 09/17/14 to indicate the resident's Physician had been notified of the blood sugar above 350.</p> <p>During an interview on 10/03/14 at 1:20 p.m., the RN Nurse Consultant indicated she could not find where the Physician had been notified of the low and high blood sugars.</p> <p>The Blood Glucose Monitoring Record, dated 09/2014, lacked documentation to indicate the resident's blood sugar had not been obtained at 4:30 on 09/10/14, 09/11/14, 09/15/14, and 09/25/14.</p> <p>During an interview on 10/03/14 at 12:50 p.m., the RN Nurse Consultant indicated she found the 4:30 p.m. blood sugar results documented on the 24-Hour report sheets and they were as followed: 09/10/14-194 09/11/14- 286 09/15/14-207 09/25/14- 276</p> <p>The RN Nurse Consultant indicated she could not verify the insulin had been given as ordered on these dates.</p> <p>The Blood Glucose Monitoring Record,</p>			

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	<p>dated 09/14/14, indicated the resident's 4:30 p.m. blood sugar on 09/06/14 was 172. The form indicated the resident had not received the eight units of insulin as ordered.</p> <p>The Blood Glucose Monitoring Record, indicated the resident's 4:30 p.m. blood sugar on 09/29/14 was 139. The form indicated the resident had not received the eight units of insulin as ordered.</p> <p>The RN Nurse Consultant indicated on 10/03/14 at 1:20 p.m., she could not verify if the insulin had been administered as ordered.</p> <p>3. Resident #D's record was reviewed on 10/03/14 at 9:45 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and congestive heart failure.</p> <p>A care plan, dated 04/12/14, indicated the resident had a diagnosis of diabetes mellitus. The intervention included, insulin as ordered.</p> <p>A Physician's Order, dated 04/29/14, indicated to monitor the resident's blood sugar before meals and at bedtime.</p> <p>A Physician's Order, dated 08/13/14, indicated Lispro (insulin) sliding scale:</p>				

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F000309 SS=D	<p>200-250-2 units, 251-300-4 units, 301-350-6 units, and 351-400-8 units.</p> <p>The Blood Glucose Monitoring Record, dated 0920/14, lacked documentation to indicate the resident's blood sugar was obtained at 4:30 on 09/14/14, 09/21/14 at 4:30 and 9 p.m., and 9 p.m. on 09/29/14.</p> <p>During an interview on 10/03/14 at 12:50 a.m., the RN Nurse Consultant indicated she located the blood sugar results on the 24-Hour report sheets and the</p> <p>This Federal Tag relates to complaint IN00157082.</p> <p>3.1-35(g)(2)</p> <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 received necessary care and services, related to monitoring, assessment, and re-evaluation of high blood sugars (hyperglycemia) and a low blood sugar</p>	F000309	Resident #B and #C were monitored for blood sugar problems and the Physician was updated on residents blood glucose levels, There were no new orders received pertaining to Resident #B and #C's insulin orders or glucose monitoring. Resident #B	10/20/2014

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	<p>(hypoglycemia) for 2 of 3 residents reviewed for diabetes mellitus in a total sample of 3. (Resident #B and #C)</p> <p>Findings include:</p> <p>1. Resident #B's record was reviewed on 10/03/14 at 10:10 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and peripheral vascular disease.</p> <p>A Care Plan, dated 08/28/14, indicated the resident had a risk for experiencing hypoglycemia and hyperglycemia due to uncontrolled diabetes mellitus. The interventions included, to observe for signs and symptoms of hypoglycemia.</p> <p>The Physician's Recapitulation Orders, dated 10/2014, indicated an order (04/02/13) to check the resident's blood sugar before meals and at bedtime. An order, dated 02/07/14, indicated to notify the Physician for a blood sugar less than 60 or higher than 350.</p> <p>The Blood Glucose Monitoring Record, dated 09/2014, indicated the resident's blood sugar on 09/04/14 at 7 a.m. was 59 and a snack was given.</p> <p>There was no documentation in the resident's Nurses' Notes for 09/04/14 to</p>		<p>and #C's medical records were reviewed and the physician notified of other (if any) episodes of blood glucose levels which warrant physician notification per ordered hi/low parameters, and/or any episodes indicating blood sugar problems.</p> <p>In effort to monitor other potential residents affected, the facility conducted audits on all diabetic residents' glucose monitoring forms. The audits were completed to ensure that other residents (if any) have been appropriately assessed in the event a resident experienced a blood sugar level which warrant physician notification per ordered hi/low parameters, and that the Physician was notified, and that the blood sugar was appropriately re-evaluated.</p> <p>To ensure that the deficient practice does not recur the facility conducted In-Service training for the licensed nurses on 10-14-2014. The content of the In-Service included information regarding conducting assessments for residents that experience blood glucose level s which warrant physician notification per ordered hi/low parameters, Proper physician notification, and re-evaluation of blood sugar completed after administration of interventions (such as a snack given) is completed as per facility policy.</p> <p>To monitor the corrective actions,</p>				

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	<p>indicate an assessment for the low blood sugar had been completed, the Physician was notified, and the blood sugar was re-evaluated after a snack was given.</p> <p>During an interview on 10/03/14 at 1:20 p.m., the RN Nurse Consultant indicated she could not find supportive documentation the resident was assessed, the Physician was notified, and the resident's blood sugar was re-evaluated after treatment of the low blood sugar.</p> <p>2. Resident #C's record was reviewed on 10/03/14 at 9:25 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and hypertension.</p> <p>A care plan, dated 06/05/14 and 09/06/14, indicated the resident was at risk for experiencing hypoglycemia and hyperglycemia related to diabetes mellitus. The interventions included to observe for signs of symptoms of hypoglycemia and hyperglycemia.</p> <p>The Physician's Recapitulation Orders, dated 09/2014, indicated an order, dated 04/02/13, to monitor the resident's blood sugar twice a day and an order on 05/26/10 to notify the Physician if the blood sugar was less than 70 or more than 350. An order dated 03/19/14 indicated to give Novolin insulin on a</p>		<p>the DON or Designee will be responsible to conduct audits on 100% of the residents with Insulin Dependent Diabetes Mellitus. Through the process of auditing, the Director of Nursing or Designee will ensure that any resident with an occurrence of high or low blood sugars levels which warrant physician notification per ordered hi/low parameters, are appropriately assessed, and the physician promptly notified, and that appropriate follow-up is conducted and documented to re-evaluate the blood sugar. The Audits will be conducted at a rate of weekly for five weeks and then monthly thereafter. The DON will be responsible to present and review any noted concerns to the Quality Assurance Committee monthly for three months and then quarterly thereafter. All systemic changes will be completed by 10/20/2014.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155323	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/03/2014
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	<p>sliding scale (insulin amount given by blood sugar level). The order indicated for 4:30 p.m. blood sugars over 110 to give eight units of insulin.</p> <p>The Blood Glucose Monitoring Record, dated 09/2014, indicated the resident's blood sugar on 09/09/14 at 7 a.m. was 53 and orange juice was given.</p> <p>There was a lack of documentation on 09/09/14 to indicate the resident had been assessed for hypoglycemia, the Physician was notified, and the blood sugar was re-evaluated after the orange juice was given.</p> <p>The Blood Glucose Monitoring Record, dated 09/2014, indicated the resident's blood sugars on 09/16/14 at 4:30 p.m. was 352 and 09/17/14 at 7 a.m. was 384 and eight units of Novolin insulin was given.</p> <p>There was a lack of documentation on 09/16/14 and 09/17/14 to indicate the resident had been assessed for hyperglycemia, the Physician had been notified and the resident's blood sugar had been re-evaluated after treatment with the eight units of insulin.</p> <p>During an interview on 10/03/14 at 1:20 p.m., the RN Nurse Consultant indicated</p>			

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	<p>she could not find supportive documentation the resident was assessed, the Physician was notified, and the resident's blood sugar was re-evaluated after treatment of the high blood sugar.</p> <p>A facility policy, titled, "Diabetes Management", received from the Administrator on 10/03/14 at 1 p.m. as current, indicated, "Hypoglycemia Treatment Procedure...If blood glucose is below 60...with or without symptoms provide the resident with one of the following...12 oz (ounces) of orange juice, Other snack of at least 150 calories...Repeat the blood glucose test 10-15 minutes later...If the interventions do not raise blood glucose the physician should be notified immediately. Nursing staff shall document: the results of the blood glucose test, notification of the physician...specific treatment used, resident's response to treatment, and any follow up...Hyperglycemia Treatment Procedure...If blood glucose is above the high end of normal range...notify the physician as soon as possible for subsequent care orders. 4. Nursing staff shall document the results of the blood glucose test, notification of the physician...specific treatment used, resident's response to treatment, and any follow up..."</p>			

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	This Federal Tag relates to complaint IN00157082. 3.1-37(a)				