

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155220	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/15/2015
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NAME OF PROVIDER OR SUPPLIER  DYER NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 601 SHEFFIELD AVE DYER, IN 46311
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F000000	<p>This visit was for the Investigation of Complaint IN00162192.</p> <p>Complaint IN00162192- Substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F309.</p> <p>Survey dates: January 14 &amp; 15, 2015</p> <p>Facility number: 000125 Provider number: 155220 AIM number: 100266740</p> <p>Survey team: Janet Adams, RN-TC</p> <p>Census bed type: SNF/NF: 140 Residential: 47 Total: 187</p> <p>Census payor type: Medicare: 47 Medicaid: 73 Other: 20 Total: 140</p> <p>Sample: 5</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC</p>	F000000	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>The facility respectfully requests a desk review.</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>16.2-3.1.</p> <p>Quality review completed on January 20, 2015, 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 under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p>						

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	<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 the Physician of elevated blood glucose levels in a timely manner for 1 of 3 residents reviewed for blood glucose monitoring for diabetes in the sample of 5. (Resident #E)</p> <p>Finding includes:</p> <p>The closed record for Resident #E was reviewed on 1/14/15 at 10:20 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, anemia, chronic kidney disease, and epilepsy.</p> <p>The 12/16/14 Minimum Data Set admission assessment indicated the resident required extensive assistance of staff for bed mobility, transfers, dressing, and personal hygiene. The assessment also indicated the resident had an active diagnosis of diabetes mellitus.</p> <p>The resident's care plans were reviewed. A care plan initiated on 12/10/14 noted the resident had the potential for acute hypo/hyperglycemic episodes secondary to a diagnosis of juvenile onset diabetes mellitus. Care plan interventions included, but were not limited to, monitor the resident's blood sugars as ordered by</p>	F000157	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility respectfully requests a desk review.</p> <p><b>F-157</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> Resident #E was discharged from the facility. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All facility residents have the potential to be affected by the same alleged deficient practice. Blood glucose records were reviewed to identify any resident who had a 'high' blood glucose level which required physician notification based on the physician order. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> In-serviced held on</p>	01/26/2015			

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	<p>the Physician and to notify the Physician as needed.</p> <p>Review of the December 2014 Glucose Monitoring Record indicated resident's blood glucose levels were to be checked four times a day at 6:00 a.m., 11:00 a.m., 4:00 p.m., and 9:00 p.m. The Glucose Monitoring Record also indicated the Physician was to be notified if the resident's blood glucose level was above 400. The Glucose Monitoring Record indicated the resident's blood glucose level was "HI" (high) with no number recorded on 12/15/14 at 9:00 p.m. The Blood Glucose Monitoring Record did not indicate the Physician was notified of the high level reading.</p> <p>The 12/15/14 Nursing Progress Notes were reviewed. An entry made at 9:35 p.m. indicated the resident's 9:00 p.m. blood glucose monitoring read "HI" and the Nurse recalibrated the glucometer (machine to read blood glucose levels) x 2 with the same results. The entry also indicated "will notify physician." The next entry was made at 9:42 p.m. This entry indicated the Physician was paged and staff were awaiting a return call. No further entries were made on 12/15/14.</p> <p>When interviewed on 1/14/15 at 12:50 p.m., the Director of Nursing indicated</p>		<p>1/23/15 by Assistant Director of Nursing/designee with the nurses regarding the following:</p> <ol style="list-style-type: none"> <li>1. Reading the physician order for blood sugar parameters which required physician notification.</li> <li>2. Documenting in the medical record any and all attempts to notify the physician.</li> <li>3. Documenting any new orders which were received based on the blood sugar result</li> <li>4. Transcribing or printing the new order and putting into the Medication Administration Record</li> </ol> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Director of Nursing/designee will audit the blood glucose monitoring records of 15 residents weekly to identify any blood sugars which required physician notification. The medical record will then be checked to ensure the physician was notified. Records found without physician notification, will be made immediately by the appropriate nurse for any necessary changes to the insulin orders or glucose monitoring. The appropriate nurse will be re-educated by Director Nursing/designee regarding physician notification of blood glucose readings. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of</p>		

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F000309 SS=D	<p>the Nurses were instructed to recheck the level and notify the Physician if the repeated level remains high. The Director of Nursing indicated the notification should be recorded on the Glucose Monitoring record or in the Nursing Progress Notes. The Director of Nursing indicated the Physician should have been notified of the high glucose monitoring result.</p> <p>The facility policy titled "Guidelines for Notifying Physicians of Clinical Problems" was reviewed on 1/14/15 at 3:06 p.m. The policy was had a revised date of April 2007. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated the Charge Nurses or Supervisors were to contact the Physician at any time if they felt the a clinical situation requires immediate discussion and management.</p> <p>This Federal tag relates to Complaint IN00162192.</p> <p>3.1-5(a)(3)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and</p>		Nursing/designee for six months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.				

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	<p>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 provide the necessary care and services to attain the resident's highest physical well- being related to assessing residents with high blood glucose levels for 1 of 3 residents reviewed for blood glucose monitoring in the sample of 5. (Resident #E)</p> <p>Finding includes:</p> <p>The closed record for Resident #E was reviewed on 1/14/15 at 10:20 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, anemia, chronic kidney disease, and epilepsy.</p> <p>The 12/12/14 Physician's History and Physical report indicated the resident was newly admitted to the facility. The report also indicated the resident had been admitted to the hospital prior to admission for elevated blood sugar levels.</p> <p>The 12/23/14 Physician's History and Physical report indicated the resident was re-admitted to the facility after being sent to the hospital for elevated blood sugar levels.</p>	F000309	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility respectfully requests a desk review.</p> <p><b>F-309</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> The corrective action for resident #E is as follows: Resident has been discharged from the facility. <b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All facility residents have the potential to be affected by the same alleged deficient practice. Medical records of</p>	01/26/2015

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	<p>The 12/16/14 Minimum Data Set admission assessment indicated the resident required extensive assistance of staff for bed mobility, transfers, dressing, and personal hygiene. The assessment also indicated the resident had an active diagnosis of diabetes mellitus.</p> <p>The resident's care plans were reviewed. A care plan initiated on 12/10/14 noted the resident had the potential for acute hypo/hyperglycemic episodes secondary to a diagnosis of juvenile onset diabetes mellitus. Care plan interventions included for staff to assess and report to the Physician any signs of hyperglycemia such as altered mental status, extreme thirst, frequent urination with increased output, fatigue, nausea/vomiting, tremors, possible seizures, dry flushed skin.</p> <p>The 12/2014 Glucose Monitoring records were reviewed. The records indicated the resident blood glucose levels were to be checked four times a day at 6:00 a.m., 11:00 a.m., 4:00 p.m., and 9:00 p.m. No scheduled sliding scale insulin coverage was ordered from 12/9/14 through 12/15/14. The resident's 9:00 p.m. blood glucose level on 12/15/14 was recorded as "HI". Further 12/2014 Glucose Monitoring records starting on 12/17/14 at 6:00 a.m. indicated the resident's</p>		<p>diabetic residents who had recently had a high blood glucose reading have been audited to identify if further physical was completed. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>In-serviced held on 1/23/15 by Assistant Director of Nursing/designee with the nurses regarding the following:</p> <ol style="list-style-type: none"> <li>1. When a resident has a 'high' blood glucose reading, further assessment should be completed of the resident's physical status related to skin, urination, tremors, mental status, urination, and/or thirst. Examples would include but not limited to: <ul style="list-style-type: none"> <li>1. Polydipsia</li> <li>2. Dry mouth</li> <li>3. Polyuria</li> <li>4. Headache</li> <li>5. Lethargy</li> <li>6. Restlessness</li> <li>7. Increase of appetite</li> </ul> </li> <li>2. Documenting the assessment and findings in the medical record including absence or presence of signs/symptoms</li> <li>3. Notification of the physician related to the assessment findings and the blood glucose result</li> <li>4. Documenting the physician response related to any changes in orders.</li> </ol> <p><b>How the corrective</b></p>				

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	<p>glucose level on 12/17/14 at 6:00 a.m. was recorded as 506. The resident's blood glucose level was recorded as "HI" on 12/26/14 at 6:00 a.m.</p> <p>The 12/15/14 Nursing Progress Notes were reviewed. An entry made at 9:35 p.m. indicated the resident's blood glucose reading was "HI" and the Nurse recalibrated the glucometer x 2 with the same results. There was no assessment of the resident's physical status related to skin, urination, tremors, mental status, urination, or thirst. The next entry in the Nursing Progress Notes was made on 12/15/14 at 9:42 p.m. This entry indicated the Physician was paged and staff were awaiting a return call. There was no physical assessment of the resident in this entry.</p> <p>The next entry in the Nursing Progress Notes was made on 12/16/14 at 4:16 a.m. This entry indicated the resident had stayed up all night and staff were continuing to monitor for any bruising, pain, or discomfort. An entry made on 12/16/14 at 2:30 p.m. indicated the resident had been lethargic right before meal time and his blood glucose reading was 379. The Nurse Practitioner was called and new orders were given to to administer 5 units of insulin (no type listed) at that time. The entry also</p>		<p><b>action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b> Director of Nursing/designee will audit the blood glucose monitoring records of 15 residents weekly to identify any blood sugars which were 'high' and/or required physician notification according to the parameter orders. The medical record will be audited to ensure further physical assessment was completed and documented related to the absence/presence of signs/symptoms of the high blood glucose level. If an assessment was not observed in the medical record, one will be completed by the charge nurse at that time and charted in the progress notes. The nurse will be re-educated by Director of Nursing/designee if further assessment was not completed and/or documented related to the 'high' blood sugar. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for six months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p>		

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	<p>indicated new orders were also given to start the resident on sliding scale insulin coverage.</p> <p>An entry made on 12/17/14 at 6:44 a.m. indicated the resident's blood glucose level was 506 and the Physician was paged . There was no assessment of the resident's physical status related to skin, urination, tremors, mental status, urination, or thirst. The next entry was made on 12/17/14 at 11:00 a.m.. This entry indicated the resident's blood sugar was registering as "HI" and the Nurse Practitioner was in the facility and gave orders for the resident to receive an additional 7 units of Novolog insulin. There was no assessment of the resident's physical status related to skin, urination, tremors, mental status, urination, or thirst in this entry.</p> <p>The 12/26/14 Nursing Progress Notes were reviewed. An entry made at 6:20 a.m. indicated the resident's blood glucose level registered "HI" and was rechecked multiple times with different glucometers and all produced the same result. There was no assessment of the resident's physical status related to skin, urination, tremors, mental status, urination, or thirst. The next entry was made at 7:40 a.m. This entry indicated the resident's blood glucose level was</p>			

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	<p>505. There was no assessment of the resident's physical status related to skin, urination, tremors, mental status, urination, or thirst. The next entry was made at 8:40 a.m. This entry indicated the resident's blood glucose level was rechecked and was now 358. There was no assessment of the resident's physical status related to skin, urination, tremors, mental status, urination, or thirst. The next entry was made at 9:58 a.m. This entry indicated the Nurse was paged to therapy "Stat" and upon arriving the therapist stated the resident had "blacked out" during a transfer from the toilet to the wheelchair. The resident was lethargic and disorientated. His blood pressure was 56/36, heart rate was 90, and his breathing was labored. The Physician was notified and an ambulance was called to transport the resident.</p> <p>The 1/2015 Glucose Monitoring record was reviewed. The resident's blood glucose level was recorded as "HI" on 1/3/15 at 11:00 a.m.</p> <p>Review of the 1/3/15 Nursing Progress Notes indicated an entry was made on 1/3/15 at 12:00 p.m. This entry indicated the Nurse spoke with the Physician regarding the blood sugar reading and new orders were received. There was no assessment of the resident's physical</p>			

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	<p>status related to skin, urination, tremors, mental status, urination, or thirst. There was no assessment of the resident's physical status related to skin, urination, tremors, mental status, urination, or thirst. An entry made at 1:54 p.m. indicated the resident's blood sugar was rechecked and was reading "HI". There was no assessment of the resident's physical status related to skin, urination, tremors, mental status, urination, or thirst. The Physician was made aware and that the family wanted the resident sent out to the hospital. An entry made at 2:05 p.m. indicated an ambulance was in the facility to transfer the resident and the resident was alert.</p> <p>When interviewed on 1/14/15 at 12:50 p.m., the Director of Nursing indicated the Nurses were instructed to recheck the level and notify the Physician if the repeat level remained high. The Director of Nursing also indicated Nursing should complete and document a physical assessment of the resident when readings were high. The Director of Nursing indicated there was no documentation of the staff assessing the resident on the above dates</p> <p>The facility policy titled "Nursing Care of the Resident with Diabetes Mellitus" was reviewed on 1/14/15 at 3:06 p.m. The</p>						

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	<p>policy had a revised date of April 2007. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated "Documentation should reflect the carefully assessed diabetic resident ..."</p> <p>The policy also indicated the resident's level of consciousness, assessment of the skin, motor weakness, urinary symptoms, and an assessment of pain should be included.</p> <p>This Federal tag relates to Complaint IN00162192.</p> <p>3.1-37(a)</p>			