

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155104	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/17/2012
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NAME OF PROVIDER OR SUPPLIER  HERITAGE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 W BUENA VISTA RD EVANSVILLE, IN 47710
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F0000	<p>This visit was for the Investigation of Complaint IN00108371.</p> <p>Complaint IN00108371-Substantiated, Federal and State deficiencies related to the allegation are cited at F309.</p> <p>Survey Dates: May 16 &amp; 17, 2012</p> <p>Facility Number: 000043 Provider Number: 155104 AIM Number: 100290960</p> <p>Survey Team: Barbara Fowler, RN, TC Jodi Meyer, RN</p> <p>Census by bed type: SNF: 17 SNF/NF: 111 Total: 128</p> <p>Census payor type: Medicare: 25 Medicaid: 66 Other: 37 Total: 128</p> <p>Sample: 7</p> <p>This deficiency reflects state findings</p>	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	cited in accordance with 410 IAC 16.2.  Quality review completed on May 22, 2012 by Bev Faulkner, RN			

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F0309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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 the necessary care and services was provided for 1 of 5 residents who suffered from hypoglycemia and received a sliding scale insulin in a total sample of 7; in that, ice water cloths were used to stimulate the resident who was in an altered state of consciousness related to low blood sugars; the resident required admission to the local hospital for treatment of hypothermia. In addition, the facility failed to ensure the resident's sliding scale insulin dose was not given in excess of the prescribed order by the physician.</p> <p>Resident G</p> <p>Findings include:</p> <p>a. The clinical record of Resident G was reviewed on 5/16/12 at 11:05 A.M., and indicated Resident G was admitted with a diagnosis of, but not limited to, diabetes mellitus II.</p>	F0309	<p>F309 HIGHEST WELL BEING</p> <p>F309 – Immediate Action – On May 17, 2012 immediately following the ISDH exit Nurses currently in facility and Nurses on Night Shift were in serviced on “Policy for Treatment of Diabetic Hyperglycemia/Hypoglycemia” and “Medication Administration Record (MAR)” and “ 5 Rights of Medication Administration” Also reviewed the Sliding Scale on Administering Insulin. F 309 – Review of Residents – On May 17, 2012 immediately following notification from the ISDH that a medication error was noted on resident G an audit of all residents with the Diagnosis of Diabetes who currently had insulin ordered with/without order for Sliding Scale coverage was completed. No residents were adversely affected by this action as it relates to insulin administration. F 309 – On Going Corrective Action – Interdisciplinary Care Plan for Potential for Hypo/Hyperglycemia r/t DM revised. Policy &amp; Procedure for Ice/Ice Pack created. Nurses/QMA will be in</p>	06/16/2012			

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	<p>Review of nursing notes included the following:</p> <p>On 5/12/12 at 9:35 P.M., Resident G's blood sugar was 75. Resident G was given peanut butter and apple juice by the facility.</p> <p>On 5/13/12 at 3:05 A.M., Resident G's blood sugar was 96 and the resident was offered a snack but refused it. The facility informed the importance of having a snack to the resident but the resident continued to refuse it .</p> <p>On 5/13/12 at 6:20 A.M., Resident G was unresponsive and had a blood sugar of 27. She was cool to touch. Resident G was given Glucagon 1 mg I.M. [intramuscularly] at that time and bathed with cold wash cloths to the face, head, neck, chest, legs, feet, and abdomen.</p> <p>At 6:35 A.M., Resident G had a blood sugar of 27 and remained unresponsive. The resident's physician triage was notified and an order was received to give Glucagon 1mg I.M. and to update triage in 15 minutes.</p> <p>At 6:37 A.M., Glucagon 1 mg IM was given to Resident G as ordered. Her vital signs indicated Resident G's temperature was 95.1 degrees Fahrenheit axillary. [The resident's normal temperature ranged between 98 and 98.2 degrees] The resident remained unresponsive and continued to be bathed with cold wash</p>		<p>serviced by June 16, 2012 on the following: "Policy &amp; Procedure for Treatment of Hyperglycemia/Hypoglycemia", Care Plan for Potential for hypo/hyperglycemia r/t DM, Policy &amp; Procedure for Medication Administration Record (MAR) , 5 Rights of Medication Administration, Review Sliding Scale Insulin Administration and Policy and Procedure for Ice/Ice Pack. F 309 – On Going Monitoring – the MDS team will review residents with Diagnosis of Diabetes Mellitus quarterly to assure the resident's care plan is appropriate. Staff Development Director/Designee will observe a minimum of one nurse administering insulin monthly; assuring the amount of insulin given corresponds with results of Blood Glucose and Sliding Scale as ordered by physician. Staff Development Director/Designee will review Policy and Procedure for TX of Hyper/Hypoglycemia, Policy and Procedure for MAR, 5 Rights of Medication Administration and Policy and Procedure for Ice/Ice Pack during orientation process.</p>				

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	<p>cloths to the face, head, neck, chest, legs, feet, and abdomen. The staff attempted to arouse the resident verbally and by touch. At 6:52 A.M., Resident G had an blood sugar of 41. The physician' triage was notified and an order was received. Glucagon 1 mg IM was given as ordered. The resident's vital signs included a temperature of 95 degrees Fahrenheit and the resident remained unresponsive. The resident also had white froth at her mouth with occasional blowing respirations. At 7:08 A.M., Resident G's blood sugar was 61. The physician's triage was informed and the facility received a new order. At 7:09 A.M., Resident G was given Glucose 45 Gel 15 Grams orally as ordered. Resident G remained unresponsive and her temperature was 95 degrees Fahrenheit. The resident continued to be bathed with cold wash cloths to the face, head, neck, chest, feet, and abdomen and the staff continued to attempt to arouse the resident. At 7:24 A.M., Resident G's blood sugar was 44 and the physician's triage was notified. The facility received the order to transfer the resident to the Emergency Room. At 7:25 A.M., the ambulance was notified to transport the resident to the Emergency Room. The resident continued to have cold wash cloths to the face, head, neck,</p>						

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	<p>chest, feet, and abdomen. The facility also continued to arouse the resident verbally and by touch. The resident remained unresponsive and the temperature was 95 degrees Fahrenheit. At 7:30 A.M., Resident G's family was informed of Resident G's condition and order to transfer the resident to the Emergency Room. At 7:45 A.M., the ambulance arrived to transport the resident to the hospital. Resident G's temperature was 95 degrees Fahrenheit at the time of the transfer.</p> <p>LPN # 1 was interviewed on 5/17/12 at 5:34 A.M. LPN #1 indicated she was notified of Resident G's condition at approximately 6:30 A.M. on 5/13/12. LPN #1 indicated she went to Resident G's room and found the resident unresponsive. LPN #1 indicated she attempted to arouse the resident both verbally and by touch.</p> <p>LPN #1 indicated she was informed of the resident Accu-check results at that time. She indicated Resident G was wrapped with iced wash cloths which were applied to her bilateral axillas and bilateral groin areas and cool wash cloths placed on the top of the resident's head and across her shoulders and around the back of her neck.</p> <p>LPN #1 indicated the resident had not had her vital signs checked prior to her</p>						

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	<p>entering the room. LPN #1 indicated initially another staff member attempted to obtain the resident's temperature axillary, but was unable to obtain due to the resident having had ice to both her axillas. LPN #1 indicated the resident's temperature was obtained orally. LPN #1 indicated the thermometer normally registers at 95 degrees Fahrenheit when use is initiated.</p> <p>LPN #1 indicated Resident G did not have the ice to her any longer that 20 - 25 minutes and the ice was removed, the resident dried and clean clothing applied to the resident. LPN #1 also indicated the resident did arouse at one point and flailed her arms and yelled out. LPN #1 indicated the Glucose Gel was given to Resident G slowly at this time.</p> <p>The staff did not receive a physician order for iced wash cloths to the resident's body, nor was there evidence in the record or interview that the physician was made aware the staff had applied iced wash cloths to the resident's body.</p> <p>On 5/16/2012 at 11:05 A.M., The Director of Nurses indicated the facility did not have a policy for use of iced wash cloths for resident care.</p> <p>The emergency transport records were reviewed on 5/17/12 at 10:30 A.M., the time of the initial call was 7:59 A.M. on</p>				

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	<p>5/13/12. The transport arrived at the facility at 8:09 a.m., the assessment notes began at 8:13 A.M. as follows: "Primary Impression: Diabetes-Hypoglycemia" "Secondary Impression:Environmental-Hypothermia" "Other Impression: R/O [rule out] -Hypoglycemia, and Nursing Facility Staff Induced Hypothermia" 8:13 A.M. through 8:56 A.M. No body temperature was recorded by the ambulance staff. The assessment was "pale color, cold temperature..." A Blood Glucose level was recorded at 8:15 A.M. of 48 mg/dl. Intravenous fluids of 10 percent Dextrose was started at 8:18 A.M. Another blood glucose was tested at 8:39 A.M. and was recorded as 157 mg/dl.</p> <p>Summary notes included: "Staff reports they have been battling with patient's blood sugar since 0300 [3:00 A.M.] today unable to get blood sugar above 40 mg/dl. Informed their treatment has consisted of 3 doses of 1 mg Glucagon IM [intramuscularly], po [ per mouth] administration of glucose gel, 'slowly' while the patient is unconscious and per the staff -'We gave her ice baths to try and arouse her...' They reported they knew she was hypoglycemic and continued to try and arouse her with frigid water.</p>						

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	<p>...Patient is very cold to touch..."</p> <p>"Heritage Staff informs us they stuck her in ice baths because they did not see any changes in the Glucagon administration...."</p> <p>"8:56 A.M. [name of hospital] staff took temperature 84 degrees F."</p> <p>The hospital emergency room record for 5/13/12 at 8:59 A.M. listed the body temperature rectal 84 degrees, pulse was 78, respirations 13, blood/pressure 105/55, Accu check was 114.</p> <p>The history and physical, dated 5/13/12, indicated the resident was being treated for encephalopathy secondary to hypoglycemia and hypothermia.</p> <p>b. Resident G had an order on 4/14/12 for Novolog sliding scale insulin to be given before meals and at bedtime. The insulin would be given in regards to the results of the Accu check (fingerstick test) blood sugar.</p> <p>The sliding scale before meals was as follows:</p> <p>Blood Sugar results</p> <p>70 - 150 = 0 units</p> <p>151 - 200 = 1 unit</p> <p>201 - 250 = 2 units</p> <p>251 - 300 = 3 units</p> <p>301 - 350 = 4 units</p> <p>351 - 400 = 5 units</p> <p>&gt; 400 = 5 units and call M.D.</p>						

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	<p>Use one half of the above amounts for the bedtime coverage, depending on the results of the blood sugar.</p> <p>On 5/8/12 at 8:30 P.M., Resident G had a blood sugar of 281. Her bedtime dose would be one half of the 3 units for the 281 blood sugar. She was to receive 1.5 units of Novolog insulin but received the entire amount of 3 units.</p> <p>On 5/9/12 at 8:30 P.M., the resident's blood sugar was 248 and the resident was given 2 units of Novolog insulin instead of 1 unit of the Novolog insulin.</p> <p>On 5/11/12 at 8:30 P.M., the resident's blood sugar was 175, she received 1 unit of Novolog insulin but she should have received 0.5 units.</p> <p>On interview of LPN # 5/17/12 at 3:35 P.M., the LPN indicated the sliding scale insulin was always given according to each physician's orders.</p> <p>This federal tag relates to Complaint IN00108371.</p> <p>3.1-37(a)</p>						

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