

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/05/2013
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NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
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F000000	<p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 7/30/13. This visit was also a PSR to the Investigation of Complaint IN00129879.</p> <p>This visit was in conjunction to the Investigation of Complaints IN00134664 and Complaint IN00135579.</p> <p>Complaint IN00129879 - Not corrected</p> <p>Survey dates: September 3, 4, & 5, 2013</p> <p>Facility number: 004700 Provider number: 155741 AIM number: 100266630</p> <p>Survey team: Marcy Smith, RN-TC Leia Alley, RN Patti Allen, SW</p> <p>Census bed type: SNF/NF: 40 Total: 40</p> <p>Census Payor type: Medicare: 11</p>	F000000	<p>We are requesting F tags 225, 226, 309 and 514 be forgiven due to the error in the resident identification process. It is stated in the 2567 that the Administrator said the incidents were not reported in a timely manner due to the holiday. This was not the case. The administrator did state that the reports were late due to the surveyors entry to the facility. We are also requesting paper compliance due to the low severity of the tags. The residents and staff at Friendship Healthcare appreciate your consideration. This plan of correction is the center's credible allegation of compliance. Preparation and/or completion of this plan of correction does not constitute admission or agreement by the provider of the facts alleged or conclusions set forth in the statement of the deficiencies. The Plan of correction is prepared and/or executed solely because it is required by state and federal law.</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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	<p>Medicaid: 29 Total: 40</p> <p>Sample: 9</p> <p>These deficiencies reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 13, 2013; by Kimberly Perigo, RN.</p>				

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F000225	Resident identification numbers	10/05/2013			

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	<p>Based on record review and interview, the facility failed to report 2 allegations of abuse to the State Reporting agency for 2 of 3 allegations of abuse reviewed for timely reporting. (Resident #2, #15, #23, and #64.)</p> <p>Findings Include:</p> <p>1) A facility Incident Report Form was reviewed on 9/4/13 at 9:30 a.m. The report indicated a Resident to Resident altercation occurred between Resident #15 and Resident #23 on 9/2/13 at 9:55 a.m. The report indicated, Resident #23 was alleged to kick Resident #15 in the thigh.</p> <p>An Email (Electronic mail) transmission report indicated the report was Emailed to the State Reporting agency on 9/3/13 at 3:54 p.m.</p> <p>2) A facility Incident Report Form was reviewed on 9/4/13 at 9:45 a.m. The report indicated a Resident to Resident altercation occurred between Resident #2 and Resident #64 on 9/2/13 at 10:35 a.m. The report indicated, Resident #2 was alleged to touch Resident #64's</p>		<p>are in conflict with resident diagnoses related to this tag. The Administrator had reviewed reportables in morning meeting with other department heads and planned to report them ASAP after morning meeting. ISDH arrived shortly thereafter, thus Administrator was delayed in reporting. The Administrator inserviced the Assistant Administrator, DON, and QA Nurse on timely reportables. All appropriate interventions were taken with both reportable instances. There was no adverse affect to any resident related to the delay in reporting. All residents residing in the facility are determined to have potential to be affected. All staff was re-educated on timeliness of reportables on 9/13/2013. The immediate need of reporting to the Administrator was stressed. A systemic plan was devised to insure timely reporting. The Administrator will be notified immediately when a reportable event occurs. The Administrator or designee will report the event to ISDH within 24 hours. In addition to the Administrator, the Assistant Administrator, Director of Nursing, and QA Nurse have all been trained on reporting events to ISDH, so an event can be reported by any of these staff members that the Administrator may designate. Reportable events are reviewed each business day in morning</p>	

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	<p>breasts.</p> <p>An Email transmission report indicated the report was Emailed to the State Reporting agency on 9/3/13 at 3:54 p.m.</p> <p>During an interview with the Administrator on 9/3/13 at 12:35 p.m., information was requested in regard to incidents that were recently reported to the state health department. The Administrator stated, "there were two reportables [incidents that needed to be reported to the State Department of Health] that happened during the holiday on 9/2/13, that have not been wrote up or reported yet."</p> <p>During an interview with the Administrator on 9/4/13 at 11:15 a.m., she indicated the reports were a few hours late to the state reporting agency, because of the holiday and the State Health Department's entrance into the facility.</p> <p>A facility policy titled, Abuse Prohibition Policy/Procedure, dated 7/26/13, indicated..."6. The Administrator of designee will report the incident to the Indiana State Department of Health immediately upon investigation of the incident."</p>		<p>meeting. This will continue as a means to ensure timely reporting of events to ISDH. The timeliness of reporting events to the ISDH will also be discussed at QA meeting quarterly on an ongoing basis as a method to monitor compliance. ADDENDUM When the Administrator is notified of a reportable event, the Administrator or designee will make the initial report to ISDH as soon as possible after such notification, not to exceed 24 hours after the event. Completion Date 10/05/2013</p>		

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	<p>This deficiency was cited on July 30, 2013. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-28(c)</p>			

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F000226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to report 2 allegations of abuse to the State Reporting agency as indicated by their policy and procedure for 2 of 3 allegations of abuse reviewed for timely reporting. (Resident #2, #15, #23, and #64.)</p> <p>Findings Include:</p> <p>1) A facility Incident Report Form was reviewed on 9/4/13 at 9:30 a.m. The report indicated a Resident to Resident altercation occurred between Resident #15 and Resident #23 on 9/2/13 at 9:55 a.m. The report indicated, Resident #23 was alleged to kick Resident #15 in the thigh.</p> <p>An Email (Electronic mail) transmission report indicated the report was Emailed to the State Reporting agency on 9/3/13 at 3:54 p.m.</p>	F000226	Resident identification numbers are in conflict with resident diagnoses related to this tag. The Administrator had reviewed reportables in morning meeting with other department heads and planned to report them ASAP after morning meeting. ISDH arrived shortly thereafter, thus Administrator was delayed in reporting. The Administrator inserviced the Assistant Administrator, DON, and QA Nurse on timely reportables. All appropriate interventions were taken with both reportable instances. There was no adverse affect to any resident related to the delay in reporting. All residents residing in the facility are determined to have potential to be affected. All staff was re-educated on timeliness of reportables on 9/13/2013. The immediate need of reporting to the Administrator was stressed. A systemic plan was devised to insure timely reporting. The Administrator will be notified immediately when a reportable event occurs. The Administrator or designee will report the event to ISDH within 24 hours. In addition to the Administrator, the	10/05/2013			

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	<p>2) A facility Incident Report Form was reviewed on 9/4/13 at 9:45 a.m. The report indicated a Resident to Resident altercation occurred between Resident #2 and Resident #64 on 9/2/13 at 10:35 a.m. The report indicated, Resident #2 was alleged to touch Resident #64's breasts.</p> <p>An Email transmission report indicated the report was Emailed to the State Reporting agency on 9/3/13 at 3:54 p.m.</p> <p>During an interview with the Administrator on 9/3/13 at 12:35 p.m., information was requested in regard to incidents that were recently reported to the state health department. The Administrator stated, "there were two reportables [incidents that needed to be reported to the State Department of Health] that happened during the holiday on 9/2/13, that have not been wrote up or reported yet."</p> <p>During an interview with the Administrator on 9/4/13 at 11:15 a.m., she indicated the reports were a few hours late to the state reporting agency, because of the holiday and the State Health Department's</p>		<p>Assistant Administrator, Director of Nursing, and QA Nurse have all been trained on reporting events to ISDH, so an event can be reported by any of these staff members that the Administrator may designate. Reportable events are reviewed each business day in morning meeting. This will continue as a means to ensure timely reporting of events to ISDH. The timeliness of reporting events to the ISDH will also be discussed at QA meeting quarterly on an ongoing basis as a method to monitor compliance. ADDENDUM When the Administrator is notified of a reportable event, the Administrator or designee will make the initial report to ISDH as soon as possible after such notification, not to exceed 24 hours after the event. Completion Date 10/05/2013</p>		

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	<p>entrance into the facility.</p> <p>A facility policy titled, Abuse Prohibition Policy/Procedure, dated 7/26/13, indicated..."6. The Administrator of designee will report the incident to the Indiana State Department of Health immediately upon investigation of the incident."</p> <p>This deficiency was cited on July 30, 2013. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-28(a)</p>				

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F000309 SS=D	<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 a resident who was refusing medications was assessed for reasons for refusal or provided with alternative administration attempts as indicated by their policy and procedure for 1 of 3 residents reviewed for medication administration in a sample of 9. (Resident #15)</p> <p>Findings include:</p> <p>The record of Resident #15 was reviewed on 9/3/13 at 10:00 a.m.</p> <p>Diagnoses for Resident #15 included, but were not limited to, diabetes mellitus, hyperthyroidism, history of hypothyroidism, bipolar disorder, schizoaffective disorder, history of breast cancer, hyperlipidemia, gastroesophageal disease, and dementia.</p> <p>An undated facility policy, received</p>	F000309	Resident identification numbers are in conflict with resident diagnoses related to this tag. Resident #15 is currently hospitalized. Upon her return, the Director of Nursing or designee will audit her Medication Administration Records each business day for no less than two months to ensure that medications are administered and documented properly, and facility policy was followed in the event of a medication refusal. All residents in the facility are identified as having potential to be affected. Nursing staff was re-educated at an inservice on 9/13/2013 and the policy/procedure for medication pass was reviewed, including steps to be taken in the event of medication refusals. The Medication Administration Records will be audited by the Director of Nursing or designee on each business day. Records of medications administered on weekends and holidays will be audited on the first business day after the weekend or holiday. These audits will include checking	10/05/2013			

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	<p>from the Nurse Consultant on 9/5/13 at 10:00 a.m., titled, "Medication Pass," indicated, "...If medications are refused it should be circled and the reason stated on the back of the MAR [Medication Administration Record] plus the resident must be educated [related to] benefits and the potential for harm when it is not taken..."</p> <p>A Plan of Correction, submitted by the facility, indicated, effective 8/29/13, "...All residents who refuse medications from one nurse will be re-approached and the medication will be offered again...All medications administered or refused will be documented on the Medication Record as indicated by initialing medication and circling it and documenting the reason for refusal on the back of the Medication Administration Record...Medication records will be audited on a daily basis until compliance is made then will be audited 3 times a week..."</p> <p>Review of the September, 2013, MAR, for Resident #15 indicated she refused medications on the following days:</p> <p>9/1/13 - Arimidex 1 mg (milligrams) daily (original order date 8/3/13). This is a drug used for breast cancer.</p>		<p>for documentation of resident refusal of medications and reason for refusal. Any nurse who fails to document refusals correctly and completely will be re-educated on the required action and documentation. Subsequent instances of inadequate documentation will be addressed with progressive disciplinary action, including termination if necessary. The audits will continue each business day until 100% compliance is achieved for five consecutive days. Then audits will reduce to twice weekly for at least two months. After two months and when the twice weekly audits show 100% compliance for at least two consecutive weeks, the audits will reduce to once weekly and continue for not less than six months. The results of the audits will be reviewed in QA each month on an ongoing basis. After six months has passed, the DON and the Quality Assurance Committee will evaluate the need for continuing the audits going forward. ADDENDUM Any medication refusals will be documented on the 24 hour report by the charge nurse. The 24 hour report will be reviewed each business day in Clinical Meeting to ensure that facility procedures were followed. Completion Date 10j/05/2013</p>				

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	<p>9/1/13 - Fanapt 4 mg. twice daily (original order date 8/3/13) This is a drug for schizophrenia.</p> <p>9/1/13 - Tricor 145 mg. daily (original order date 8/3/13) This is a drug for cholesterol.</p> <p>9/1/13 - Lamictal 25 mg. daily (original order dated 8/3/13) This is an anti seizure medication.</p> <p>9/1/13 - Glucophage 500 mg. daily (original order date 8/3/13) This is a drug for diabetes. mellitus.</p> <p>9/1/13 - metoprolol 25 mg. daily (original order date 8/3/13) This is a drug for high blood pressure.</p> <p>9/1/13 - Prilosec 40 mg. daily (original order date 8/3/13) This is a drug to help lower stomach acid.</p> <p>9/1/13 - Trihexyphen 2 mg. daily (original order date 8/3/13) This is an anti-Parkinson medication.</p> <p>9/1/13 - Synthroid 50 mcg (micrograms) daily (original order date 8/3/13). This is a thyroid medication.</p> <p>A nurse's note on the back of the MAR indicated Resident #15 refused all her medications on 9/1/13. There was no reason given for the refusals or mention of alternative approaches attempted or education provided.</p> <p>9/2/13 - Synthroid, Prilosec. These medications were circled as refused, but no reason given for refusal or</p>						

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	<p>mention of education provided or re-approaches attempted.</p> <p>9/3/13 - Prilosec. This was circled as refused, but no reason given for refusal or mention of education provided or re-approaches attempted.</p> <p>9/4/13 - Prilosec. This was circled as refused, but no reason given for refusal or mention of education provided or re-approaches attempted.</p> <p>A physician's order, with an original date of 8/3/13, indicated Resident #15 was supposed to have accuchecks (a finger stick blood test to measure blood sugar) before meals and at bedtime. She was to receive HumaLog insulin on a sliding scale based on the results of her accuchecks.</p> <p>On 8/29/13, there were no results for the 6:00 a.m. and 11:00 a.m., accuchecks. On the back of the MAR the nurse had written, "refused." No reasons were given for the refusals or mention of any education provided or reproaches attempted. No sliding scale insulin was administered at these times.</p> <p>On 8/30/13, there were no results for the 6:00 a.m., 11:00 a.m. 4:00 p.m. or</p>			

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	<p>bedtime accuchecks. The nurse had written on the back of the MAR, "Refused." No reasons were given for the refusals or mention of education provided or reproaches attempted. No sliding scale insulin was administered at these times.</p> <p>The facility indicated in their Plan of Correction that, effective 8/29/13, "The Medication records will be audited on a daily basis until compliance is made then will be audited 3 times a week..."</p> <p>During an interview with the Director of Nursing on 9/4/13, at 11:00 a.m., she indicated she was auditing Medication records for 9/3/13 at that time. She indicated no audits had been done on Medication records for 8/29/13, 8/30/13, 8/31/13, 9/1/13 or 9/2/13.</p> <p>This deficiency was cited on July 30, 2013. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-37(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/05/2013
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F000514 SS=D	<p>483.75(I)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure Medication Administration Records were documented accurately and completely for 1 of 4 residents whose clinical records were reviewed in a sample of 9. (Resident #15)</p> <p>Findings include:</p> <p>The record of Resident #15 was reviewed on 9/3/13 at 10:00 a.m.</p> <p>Diagnoses for Resident #15 included, but were not limited to, diabetes mellitus, hyperthyroidism, history of hypothyroidism, bi polar disorder, schizoaffective disorder, history of breast cancer, hyperlipidemia, gastroesophageal disease, and dementia.</p>	F000514	Resident identification numbers are in conflict with resident diagnoses related to this tag. Resident #15 is currently hospitalized. Upon her return, the Director of Nursing or designee will audit her Medication Administration Records each business day for no less than two months to ensure that medications are administered and documented properly, and facility policy was followed in the event of a medication refusal. All residents in the facility are identified as having potential to be affected. Nursing staff was re-educated at an inservice on 9/13/2013 and the policy/procedure for medication pass was reviewed, including steps to be taken in the event of medication refusals. The Medication Administration Records will be audited by the	10/01/2013			

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	<p>An undated facility policy, received from the Nurse Consultant on 9/5/13 at 10:00 a.m., titled, "Medication Pass," indicated, "...If medications are refused it should be circled and the reason stated on the back of the MAR [Medication Administration Record] plus the resident must be educated [related to] benefits and the potential for harm when it is not taken..."</p> <p>A Plan of Correction, submitted by the facility, indicated, effective 8/29/13, "...All residents who refuse medications from one nurse will be re-approached and the medication will be offered again...All medications administered or refused will be documented on the Medication Record as indicated by initialing medication and circling it and documenting the reason for refusal on the back of the Medication Administration Record...Medication records will be audited on a daily basis until compliance is made then will be audited 3 times a week..."</p> <p>Review of the September, 2013, MAR, for Resident #15 indicated she refused medications on the following days:</p> <p>9/1/13 - Arimidex 1 mg (milligrams)</p>		<p>Director of Nursing or designee on each business day. Records of medications administered on weekends and holidays will be audited on the first business day after the weekend or holiday. These audits will include checking for documentation of resident refusal of medications and reason for refusal. Any nurse who fails to document refusals correctly and completely will be re-educated on the required action and documentation. Subsequent instances of inadequate documentation will be addressed with progressive disciplinary action, including termination if necessary. The audits will continue each business day until 100% compliance is achieved for five consecutive days. Then audits will reduce to twice weekly for at least two months. After two months and when the twice weekly audits show 100% compliance for at least two consecutive weeks, the audits will reduce to once weekly and continue for not less than six months. The results of the audits will be reviewed in QA each month on an ongoing basis. After six months has passed, the DON and the Quality Assurance Committee will evaluate the need for continuing the audits going forward. Date of Completion 10/01/2013</p>		

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	<p>daily (original order date 8/3/13). This is a drug used for breast cancer. 9/1/13 - Fanapt 4 mg. twice daily (original order date 8/3/13) This is a drug for schizophrenia. 9/1/13 - Tricor 145 mg. daily (original order date 8/3/13) This is a drug for cholesterol. 9/1/13 - Lamictal 25 mg. daily (original order dated 8/3/13) This is an anti seizure medication. 9/1/13 - Glucophage 500 mg. daily (original order date 8/3/13) This is a drug for diabetes. mellitus. 9/1/13 - metoprolol 25 mg. daily (original order date 8/3/13) This is a drug for high blood pressure. 9/1/13 - Prilosec 40 mg. daily (original order date 8/3/13) This is a drug to help lower stomach acid. 9/1/13 - Trihexyphen 2 mg. daily (original order date 8/3/13) This is an anti-Parkinson medication. 9/1/13 - Synthroid 50 mcg (micrograms) daily (original order date 8/3/13). This is a thyroid medication.</p> <p>A nurse's note on the back of the MAR indicated Resident #15 refused all her medications on 9/1/13. There was no reason given for the refusals or mention of alternative approaches attempted or education provided.</p> <p>9/2/13 - Synthroid, Prilosec. These</p>						

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	<p>medications were circled as refused, but no reason given for refusal or mention of education provided or re-approaches attempted.</p> <p>9/3/13 - Prilosec. This was circled as refused, but no reason given for refusal or mention of education provided or re-approaches attempted.</p> <p>9/4/13 - Prilosec. This was circled as refused, but no reason given for refusal or mention of education provided or re-approaches attempted.</p> <p>A physician's order, with an original date of 8/3/13, indicated Resident #15 was supposed to have accuchecks (a finger stick blood test to measure blood sugar) before meals and at bedtime. She was to receive HumaLog insulin on a sliding scale based on the results of her accuchecks.</p> <p>On 8/29/13, there were no results for the 6:00 a.m. and 11:00 a.m., accuchecks. On the back of the MAR the nurse had written, "refused." No reasons were given for the refusals or mention of any education provided or reproaches attempted. No sliding scale insulin was administered at these times.</p>			

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	<p>On 8/30/13, there were no results for the 6:00 a.m., 11:00 a.m. 4:00 p.m. or bedtime accuchecks. The nurse had written on the back of the MAR, "Refused." No reasons were given for the refusals or mention of education provided or reproaches attempted. No sliding scale insulin was administered at these times.</p> <p>The facility indicated in their Plan of Correction that, effective 8/29/13, "The Medication records will be audited on a daily basis until compliance is made then will be audited 3 times a week..."</p> <p>During an interview with the Director of Nursing on 9/4/13 at 11:00 a.m., she indicated she was auditing Medication records for 9/3/13, at that time. She indicated no audits had been done on Medication records for 8/29/13, 8/30/13, 8/31/13, 9/1/13, or 9/2/13.</p> <p>This deficiency was cited on July 30, 2013. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>						

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