

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155763	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/31/2014
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NAME OF PROVIDER OR SUPPLIER  NORTH RIDGE VILLAGE NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 600 TRAIL RIDGE RD ALBION, IN 46701
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00142971.</p> <p>Survey dates: January 23, 24, 28, 29, 30, 31, 2014.</p> <p>Facility number: 011296 Provider number: 155763 AIM number: 200827620</p> <p>Survey team: Tim Long, RN-TC Carol Miller, RN Rick Blain, RN Diane Nilson, RN</p> <p>Census bed type: SNF/NF: 59 Residential: 6 Total: 65</p> <p>Census Payor type: Medicare: 13 Medicaid: 32 Other: 20 Total: 65</p> <p>These deficiencies reflect state findings cited in accordance with</p>	F000000		
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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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	410 IAC 16.2.  Quality review completed on February 4, 2014 by Randy Fry RN.			

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F000157 SS=D	<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> <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 observation, record review, and interview, the facility failed to notify the physician regarding a change in a resident's physical status regarding low blood</p>	F000157	This plan of correction is to serve as North Ridge Village Nursing and Rehab Center's credible allegation of compliance. Submission of this plan of correction does not constitute an	03/02/2014	

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	<p>sugar readings for 1 Resident in a sample of 17 reviewed for physician orders, Resident #4.</p> <p>Findings include:</p> <p>Resident #4 was interviewed, at 3:45 p.m., on 1/23/14, and indicated he had told the nurse he wanted a blood sugar test because he felt tingly and felt his blood sugar was dropping. RN#1 was observed in the resident's room, at 3:50 p.m., on 1/23/14, and indicated she had taken a blood sugar reading and indicated the blood sugar was 66. She was then observed assisting the resident to eat a nutrition bar.</p> <p>The record for Resident #4 was reviewed, beginning at 10:43 a.m., on 1/29/14 and indicated the resident was admitted to the facility on 8/14/13, and re-admitted on 11/30/13. Diagnoses included, but not limited to: Quadriplegia and chronic pain.</p> <p>There was no documentation regarding the assessment or blood sugar reading taken on 1/23/14 by RN #1, and no documentation to indicate the physician had been notified.</p> <p>Nursing notes between 12/1/13 and</p>		<p>admission by North Ridge Village Nursing and Rehab Center or its' management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. It is the practice of North Ridge Village Nursing and Rehab Center to 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 (ie., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (ie., 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 also promptly notifies the resident and, if known, the resident's legal representative or interested family member when there is a change in room or</p>				

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	<p>1/24/14 were reviewed, and the only note regarding blood sugar readings was a nursing note, dated 12/27/13, at 6:00 p.m., with no staff signature, which indicated, "Resident request his blood sugar be checked. Reading 53. Juice drank et (and) rice crispy treat. Also evening meal."</p> <p>There was no documentation of the blood sugar being re-checked, and no documentation to indicate the physician had been notified.</p> <p>Review of a laboratory value for a Basic Metabolic Panel, dated 1/15/14, indicated the glucose (blood sugar level) was 85, with reference range indicating the normal value to be 70-110 mg/dl(milligram/deciliter).</p> <p>Resident #4 was interviewed again, at 1:30 p.m., on 1/29/14, and indicated after eating the nutrition bar on 1/23/14, his blood sugar came up to 118. He indicated he had felt "tingly" and could tell his blood sugar was dropping. He indicated he had been diagnosed with hypoglycemia in the past, and sometimes would have episodes of low blood sugar, sometimes a couple times a week, sometimes only once a month.</p>		<p>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 records and periodically updates the address and phone number of the resident's legal representative or interested family member. I. Resident #4's physician was made aware of the change in physical status regarding a low blood glucose reading and was reassessed for hypoglycemia. This resident did not sustain any measurable negative outcomes as a result of this practice. Resident #4 now has a diagnosis of hypoglycemia and a physician's order to check his blood glucose if he is symptomatic and to follow the diabetic protocol. II. All residents are at equal risk to be affected by this deficient practice. There have been no other reports of non-diagnosed residents requesting glucose testing or intervention. III. The facility protocol entitled "diabetic protocol" was reviewed and found to be thorough and complete, including when a physician should be notified of a low blood glucose level. Licensed nurses and qualified medication aides have been re-educated on this protocol along with standard practices for documentation of nursing assessments.IV. The DON or her</p>		

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	<p>RN #1 was interviewed, at 2:15 p.m., on 1/29/14, and indicated Resident #4 had asked her to take his blood sugar reading on 1/23/14, and the blood sugar was low. She indicated she gave him a nutrition bar and the resident's blood sugar came back up, but she couldn't remember what the second reading was. She indicated she should have documented the blood sugar, but thought she had passed the information on in report.</p> <p>LPN #2 was interviewed, at 2:30 p.m., on 1/29/14, and indicated she didn't normally work on the hall where the resident resided, but remembered the resident had requested a blood sugar reading once before while she was working because he indicated he was not feeling well. She couldn't remember when this occurred, but thought it was when he was first admitted to the facility. She indicated if the resident's blood sugar dropped, she would document this and contact the physician to let him know. She indicated even though she didn't normally work on that hall, she had overheard the resident, in the past, asking other nurses to check his blood sugar because he wasn't</p>		<p>designee is conducting quality improvement audits to ensure that the physician is notified according to the diabetic protocol for 100% of residents that experience an abnormal blood glucose level. The "abnormal finger stick blood glucose flow sheet" of diabetic residents will be monitored five times weekly for a week then weekly for one month then every other week for 5 months. Results of these audits will be reported to the QA committee monthly.</p>		

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	<p>feeling well.</p> <p>The Director of Nursing Services (DNS) was interviewed, at 9:00 a.m., on 1/30/14, regarding the lack of documentation of the blood sugar assessment. She indicated the resident was not diabetic, and she was not aware of a hypoglycemic diagnosis, and the nurses could do a blood sugar as a nursing measure if the resident requested it. She indicated it wasn't necessary to document the blood sugar or contact the physician unless it was a significant change.</p> <p>LPN #3 was interviewed at 9:17 a.m., on 1/30/13, and indicated she normally worked day shift on the resident's hall. She indicated she thought the resident might have asked her to check his blood sugar once a few months ago, but couldn't remember if she had documented the results because she remembered it being ok.</p> <p>The DNS was interviewed, at 2:05 p.m., on 1/30/14, and indicated the physician was notified today of the 2 low blood sugar readings and did not write any new orders related to this. She indicated she would call</p>						

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	<p>the physician if a blood sugar reading was less than 60 mg/dl. She indicated the facility policy on diabetics was to call the physician on anything less than 60.</p> <p>Review of the policy for Diabetic Protocol, provided by the DNS, at 2:40 p.m., on 1/30/14, and reviewed at 2:55 p.m., on 1/30/14, indicated the following: "For asymptomatic and responsive residents with hypoglycemia (&lt;(less than) 60 mg/dl or less than the physician-ordered parameter): a. give the resident 15 grams of carbohydrates orally (4 ounces juice or 5-6 ounces of soda); followed by a complex carbohydrate such as cheese or milk. b. recheck blood glucose in 15 minutes." The policy also indicated if blood sugar was less than 60 mg/dl to repeat the oral glucose and recheck the blood glucose in 15 minutes, and if no improvement, notify the physician.</p> <p>The policy indicated for a resident who was symptomatic, but responsive, residents with hypoglycemia were to immediately be given 15 grams of carbohydrates orally followed by a complex</p>			

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	<p>carbohydrate such as cheese or milk, or be given one tube of Insta-Glucose, then recheck the blood glucose in 15 minutes. Also, repeat treatment if indicated, recheck blood glucose in 15 minutes, and notify the physician if no improvement.</p> <p>Review of the policy for Change in a Resident's Condition or Status, dated 04/2012, provided by the corporate RN, at 9:26 a.m., on 1/30/14, indicated the following: "The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: e. A significant change in the resident's physical/emotional/mental condition." The policy also indicated, "The Nurse Supervisor/Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. "</p> <p>3.1-5(a)(2)</p>				

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>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 interview and record review, the facility failed to ensure a Physician's Order for a sliding scale insulin coverage was transcribed correctly for a diabetic resident. This deficiency affected 1 of 2 diabetic residents who were reviewed for sliding scale insulin coverage in a sample of 17 (Resident #88).</p> <p>Findings include:</p> <p>Resident #88's chart was reviewed on 1/18/14 at 1:30 p.m. Resident #88's diagnoses included, but were not limited to, diabetes mellitus.</p> <p>Physician's Orders dated 12/5/13 indicated blood sugar accuchecks before every meal and at bedtime and to administer Humalog insulin</p>	F000282	<p>It is the practice of North Ridge Village Nursing and Rehab Center to ensure that services provided or arranged by the facility are provided by qualified persons in accordance with each resident's written plan of care. I. Resident #88 discharged to home after his rehabilitation. II. Residents that have physician orders for sliding scale insulin coverage are at risk. Physician orders for resident's that have sliding scale insulin coverage were reviewed for accuracy. No significant issues were noted in this audit. III. The facility protocol for ongoing quality assurance checks of physician orders was reviewed and revised as needed. This includes a two-person check system for all new physician orders to ensure accuracy. Licensed nurses and qualified medication aides have been</p>	03/02/2014	

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	<p>as needed according to a sliding scale. If the resident's blood sugar results were the following: 151-200 give 2 units, 201-250 give 4 units, 251-300 give 6 units, 301-350 give 8 units, 351-400 give 10 units, and if the blood sugar results were greater than 400 call the Physician.</p> <p>The December 2013 Medication Administration Record (MAR) indicated to obtain blood sugar accuchecks before every meal and at bedtime and to administer Humalog insulin as needed according to a sliding scale. If the resident's blood sugar results were: 151-200 give 2 units, 201-250 give 4 units, 251-300 give 6 units, 351-400 give 8 units, and if the blood sugar results were greater than 400 call the Physician.</p> <p>The Physician's Orders dated 12/5/13 for Humalog insulin sliding scale coverage for a result of 301-350 was not transcribed onto the December 2013 MAR and the insulin dosage was the incorrect amount for the sliding scale if the blood sugar results were 351-400 give 8 units instead of the ordered</p>		<p>re-educated on this policy.IV. The DON or her designee will conduct a quality improvement audit of physician orders to ensure accurate transcription five times weekly for four weeks, weekly for four weeks, and monthly for four months. The audit size will be a random sample of ten (10) physician orders per prescribed audit period. Results of these audits will be reported to the QA committee monthly.</p>				

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	<p>10 units of insulin.</p> <p>The December 2013 MAR indicated: on 12/6/13 at 7:00 a.m. the resident's blood sugar result was 368 and was given 8 units of Humalog insulin instead of the ordered 10 units; on 12/6/13 at 11:00 a.m. the blood sugar result was 389 and was given 8 units of insulin instead of the ordered 10 units; on 12/6/13 at 4:00 p.m. the blood sugar result was 416.</p> <p>The Physician's Order dated 12/6/13 indicated: 1. give Humalog insulin 12 units at 1700 (5:00 p.m.) "...for abnormal high blood sugar..." 2. Lantus insulin administer 20 units every morning.</p> <p>On 12/7/13 at 7:00 a.m. the blood sugar was 368 and was given 8 units instead of the ordered 10 units of insulin.</p> <p>On 12/7/13 at 11:00 a.m. the blood sugar was 397 and received 8 units instead of the ordered 10 units.</p> <p>On 12/7/13 at 4:00 p.m. the blood sugar was 470. The Physician's Order dated 12/7/13</p>						

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	<p>at 4:00 p.m. indicated:</p> <ol style="list-style-type: none"> <li>1. give Humalog insulin 15 units now for a blood sugar of 470.</li> <li>2. Start Lantus insulin and administer 20 units every night at bedtime.</li> </ol> <p>On 12/7/13 at 8:00 p.m. the resident's blood sugar was 512. Physician's Order dated 12/7/13 at 7:00 p.m. indicated:</p> <ol style="list-style-type: none"> <li>1. give Humalog insulin 20 units now for a blood sugar of 512.</li> <li>2. Increase the dosage of Lantus insulin from 20 units to 60 units administer every morning and every evening.</li> </ol> <p>On 12/8/13 at 4:00 p.m. the resident's blood sugar was 385 and received Humalog insulin 8 units instead of the ordered 10 units.</p> <p>On 12/8/13 at 8:00 p.m. the resident's blood sugar result was 417. The Physician's order dated 12/8/13 indicated give Humalog insulin 10 units now for blood sugar of 417.</p> <p>On 1/2/14 the Physician's Order for the sliding scale coverage for insulin was clarified by LPN #7 and indicated if the blood sugar results are 301-350 give 8 units, and if the</p>				

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	<p>blood sugar results are 351-400 give 10 units of insulin.</p> <p>On 1/30/14 at 11:00 a.m. an interview with the Director Nursing Service (DNS) indicated LPN #5 who had admitted the resident on 12/5/13 had not transcribed the Physician's Order for the sliding scale insulin coverage correctly to the December 2013 MAR. The DNS further indicated the 3rd shift LPN #6 was responsible for checking all new Physician's Orders against the MAR and should had noticed the sliding scale for the insulin coverage was incorrect. The 3rd shift nurse LPN #6 had initialed the Physician's order for the sliding scale insulin coverage indicating that she checked the Physician's Orders against the MAR on 12/5/13. On 1/2/14 LPN #7 had called Resident #88's Physician and clarified the sliding scale insulin coverage order.</p> <p>3.1-35(g)(2)</p>			
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NAME OF PROVIDER OR SUPPLIER  NORTH RIDGE VILLAGE NURSING & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 600 TRAIL RIDGE RD ALBION, IN 46701			
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F000309 SS=D	<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 interview, and record review, the facility failed to ensure a Physician's Order for a sliding scale insulin coverage was transcribed correctly for a diabetic resident. This deficiency affected 1 of 2 diabetic residents who were reviewed for sliding scale insulin coverage in a sample of 17 (Resident #88).</p> <p>Findings include:</p> <p>Resident #88's chart was reviewed on 1/18/14 at 1:30 p.m. Resident #88's diagnoses included, but were not limited to, diabetes mellitus.</p> <p>Physician's Orders dated 12/5/13 indicated blood sugar accuchecks before every meal and at bedtime and to administer Humalog insulin as needed according to a sliding scale. If the resident's blood sugar results were the following: 151-200 give 2 units, 201-250 give 4 units, 251-300 give 6 units,</p>	F000309	<p>It is the practice of North Ridge Village Nursing and Rehab Center to ensure each resident receives and the facility provides 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. I. Resident #88 discharged to home after his rehabilitation.II. Residents that have physician orders for sliding scale insulin coverage are at risk. Physician orders for resident's that have sliding scale insulin coverage were reviewed for accuracy. No significant issues were noted in this audit. III. The facility protocol for ongoing quality assurance checks of physician orders was reviewed and revised as needed. This includes a two-person check system for all new physician orders to ensure accuracy. Licensed nurses and qualified medication aides have been re-educated on this policy. IV. The DON or her designee will conduct a quality improvement audit of physician</p>	03/02/2014			

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	<p>301-350 give 8 units, 351-400 give 10 units, and if the blood sugar results were greater than 400 call the Physician.</p> <p>The December 2013 Medication Administration Record (MAR) indicated to obtain blood sugar accuchecks before every meal and at bedtime and to administer Humalog insulin as needed according to a sliding scale. If the resident's blood sugar results were: 151-200 give 2 units, 201-250 give 4 units, 251-300 give 6 units, 351-400 give 8 units, and if the blood sugar results were greater than 400 call the Physician.</p> <p>The Physician's Orders dated 12/5/13 for Humalog insulin sliding scale coverage for a result of 301-350 was not transcribed onto the December 2013 MAR and the insulin dosage was the incorrect amount for the sliding scale if the blood sugar results were 351-400 give 8 units instead of the ordered 10 units of insulin.</p> <p>The December 2013 MAR indicated: on 12/6/13 at 7:00 a.m. the resident's blood sugar result was 368 and was given 8 units of</p>		<p>orders to ensure accurate transcription five times weekly for four weeks, weekly for four weeks, and monthly for four months. The audit size will be a random sample of ten (10) physician orders per prescribed audit period. Results of these audits will be reported to the QA committee monthly.</p>		

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	<p>Humalog insulin instead of the ordered 10 units.</p> <p>on 12/6/13 at 11:00 a.m. the blood sugar result was 389 and was given 8 units of insulin instead of the ordered 10 units.</p> <p>on 12/6/13 at 4:00 p.m. the blood sugar result was 416. The Physician's Order dated 12/6/13 indicated</p> <ol style="list-style-type: none"> <li>1. give Humalog insulin 12 units at 1700 (5:00 p.m.) "...for abnormal high blood sugar..."</li> <li>2. Lantus insulin administer 20 units every morning.</li> </ol> <p>On 12/7/13 at 7:00 a.m. the blood sugar was 368 and was given 8 units instead of the ordered 10 units of insulin.</p> <p>On 12/7/13 at 11:00 a.m. the blood sugar was 397 and received 8 units instead of the ordered 10 units.</p> <p>On 12/7/13 at 4:00 p.m. the blood sugar was 470. The Physician's Order dated 12/7/13 at 4:00 p.m. indicated</p> <ol style="list-style-type: none"> <li>1. give Humalog insulin 15 units now for a blood sugar of 470.</li> <li>2. Start Lantus insulin and administer 20 units every night at bedtime.</li> </ol>						

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	<p>On 12/7/13 at 8:00 p.m. the resident's blood sugar was 512. Physician's Order dated 12/7/13 at 7:00 p.m. indicated</p> <ol style="list-style-type: none"> <li>1. give Humalog insulin 20 units now for a blood sugar of 512.</li> <li>2. Increase the dosage of Lantus insulin from 20 units to 60 units administer every morning and every evening.</li> </ol> <p>On 12/8/13 at 4:00 p.m. the resident's blood sugar was 385 and received Humalog insulin 8 units instead of the ordered 10 units.</p> <p>On 12/8/13 at 8:00 p.m. the resident's blood sugar result was 417. The Physician's order dated 12/8/13 indicated give Humalog insulin 10 units now for blood sugar of 417.</p> <p>On 1/2/14 the Physician's Order for the sliding scale coverage for insulin was clarified by LPN #7 and indicated if the blood sugar results are 301-350 give 8 units, and if the blood sugar results are 351-400 give 10 units of insulin.</p> <p>On 1/30/14 at 11:00 a.m. an interview with the Director Nursing</p>						

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	<p>Service (DNS) indicated LPN #5 who had admitted the resident on 12/5/13 had not transcribed the Physician's Order for the sliding scale insulin coverage correctly to the December 2013 MAR. The DNS further indicated the 3rd shift LPN #6 was responsible for checking all new Physician's Orders against the MAR and should had noticed the sliding scale for the insulin coverage was incorrect. The 3rd shift nurse LPN #6 had initialed the Physician's order for the sliding scale insulin coverage indicating that she checked the Physician's Orders against the MAR on 12/5/13. On 1/2/14 LPN #7 had called Resident #88's Physician and clarified the sliding scale insulin coverage order.</p> <p>3.1-37(a)</p>			

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F000514 SS=D	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE 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 observation, record review, and interview, the facility failed to document an assessment regarding a low blood sugar result, for 1 Resident in a sample of 17 reviewed for documentation, Resident #4, and failed to document that the physician was notified in regard to clarification of a sliding scale insulin order, for 1 resident in a sample of 17 reviewed for physician orders, Resident #88.</p> <p>Findings include:</p> <p>Resident #4 was interviewed, at 3:45 p.m., on 1/23/14, and indicated he had told the nurse he wanted a blood sugar test because he felt tingly and felt his blood sugar was dropping. RN#1 was observed in</p>	F000514	It is the practice of North Ridge Village Nursing and Rehab Center to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. 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 result of any preadmission screening conducted by the State; and progress notes.l. Resident #4: The physician was made aware of the change in physical status regarding a low blood glucose reading and was re assessed for hypoglycemia. This resident did not sustain any measurable negative outcomes as a result of this practice.	03/02/2014			

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	<p>the resident's room, at 3:50 p.m., on 1/23/14, and indicated she had done a blood sugar reading and indicated the blood sugar was 66. She was then observed assisting the resident to eat a nutrition bar.</p> <p>The record for Resident #4 was reviewed, beginning at 10:43 a.m., on 1/29/14 and indicated the resident was admitted to the facility on 8/14/13, and re-admitted on 11/30/13. Diagnoses included, but not limited to: Quadriplegia and chronic pain.</p> <p>There was no documentation regarding the assessment or blood sugar reading taken on 1/23/14 by RN #1.</p> <p>Resident #4 was interviewed again, at 1:30 p.m., on 1/29/14, and indicated after eating the nutrition bar on 1/23/14, his blood sugar came up to 118. He indicated he had felt "tingly" and could tell his blood sugar was dropping. He indicated he had been diagnosed with hypoglycemia in the past, and sometimes would have episodes of low blood sugar, sometimes a couple times a week, sometimes only once a month.</p> <p>RN #1 was interviewed, at 2:15</p>		<p>Resident #4 now has a diagnosis of hypoglycemia and a physician's order to check his blood glucose if he is symptomatic and to follow the diabetic protocol. Resident #88: Resident #88 discharged to home after his rehabilitation. II. Resident #4: All residents are at equal risk to be affected by this deficient practice. There have been no other reports of non-diagnosed residents requesting glucose testing or intervention. Resident #88: All residents are at equal risk to be affected by this deficient practice. No other instances such as the one cited during survey have been noted by facility administration. III. Resident #4: The facility protocol entitled "diabetic protocol" was reviewed and found to be thorough and complete. Licensed nurses and qualified medication aides have been re-educated on this protocol along with standard practices for documentation of nursing assessments. Resident #88: The facility policy and procedure for physician notification was reviewed and found to be thorough and complete. Licensed nurses and qualified medication aides have been re-educated on this policy. IV. Resident #4: The DON or her designee is conducting quality improvement audits to ensure that 100% of residents that experience abnormal blood glucose levels</p>				

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	<p>p.m., on 1/29/14, and indicated Resident #4 had asked her to take his blood sugar reading on 1/23/14, and the blood sugar was low. She indicated she gave him a nutrition bar and the resident's blood sugar came back up, but she couldn't remember what the second reading was. She indicated she should have documented the blood sugar, but thought she had passed the information on in report.</p> <p>The Director of Nursing Services (DNS) was interviewed, at 9:00 a.m., on 1/30/14, regarding the lack of documentation of the blood sugar assessment. She indicated the resident was not diabetic, and she was not aware of a hypoglycemic diagnosis, and the nurses could do a blood sugar as a nursing measure if the resident requested it. She indicated it wasn't necessary to document the blood sugar or contact the physician unless it was a significant change.</p> <p>LPN #3 was interviewed at 9:17 a.m., on 1/30/13, and indicated she normally worked day shift on the resident's hall. She indicated she thought the resident might have asked her to check his blood sugar</p>		<p>have these levels documented according to the diabetic protocol. Diabetic residents will be monitored five times weekly for a week then weekly for one month then every other week for 5 months. Results of these audits will be reported to the QA committee monthly. Resident #88: The DON or her designee will conduct a quality improvement audit of physician orders to ensure physician notification documentation five times weekly for four weeks, weekly for four weeks, and monthly for four months. The audit size will be a random sample of ten (10) physician orders per prescribed audit period. Results of these audits will be reported to the QA committee monthly.</p>		

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	<p>once a few months ago, but couldn't remember if she had documented the results because she remembered it being ok.</p> <p>Review of the policy for Change in a Resident's Condition or Status, dated, 04/2012, provided by the corporate RN, at 9:26 a.m., on 1/30/14, indicated the following: "The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: e. A significant change in the resident's physical/emotional/mental condition." The policy also indicated, "The Nurse Supervisor/Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. "</p> <p>2. Resident #88's chart was reviewed on 1/18/14 at 1:30 p.m. Resident #88's diagnoses included, but were not limited to, diabetes mellitus.</p> <p>Physician's Orders dated 12/5/13 indicated blood sugar accuchecks before every meal and at bedtime and to administer Humalog insulin as needed according to a sliding</p>			

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	<p>scale. If the resident's blood sugar results were the following: 151-200 give 2 units, 201-250 give 4 units, 251-300 give 6 units, 301-350 give 8 units, 351-400 give 10 units, and if the blood sugar results were greater than 400 call the Physician.</p> <p>The December 2013 Medication Administration Record (MAR) indicated to obtain blood sugar accuchecks before every meal and at bedtime and to administer Humalog insulin as needed according to a sliding scale. If the resident's blood sugar results were: 151-200 give 2 units, 201-250 give 4 units, 251-300 give 6 units, 351-400 give 8 units, and if the blood sugar results were greater than 400 call the Physician.</p> <p>The Physician's Orders dated 12/5/13 for Humalog insulin sliding scale coverage for a result of 301-350 was not transcribed onto the December 2013 MAR and the insulin dosage was the incorrect amount for the sliding scale if the blood sugar results were 351-400 give 8 units instead of the ordered 10 units of insulin.</p>						

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	<p>The December 2013 MAR indicated: on 12/6/13 at 7:00 a.m. the resident's blood sugar result was 368 and was given 8 units of Humalog insulin instead of the ordered 10 units.</p> <p>On 12/6/13 at 11:00 a.m. the blood sugar result was 389 and was given 8 units of insulin instead of the ordered 10 units. on 12/6/13 at 4:00 p.m. the blood sugar result was 416. The Physician's Order dated 12/6/13 indicated</p> <ol style="list-style-type: none"> <li>1. give Humalog insulin 12 units at 1700 (5:00 p.m.) "...for abnormal high blood sugar..."</li> <li>2. Lantus insulin administer 20 units every morning.</li> </ol> <p>On 12/7/13 at 7:00 a.m. the blood sugar was 368 and was given 8 units instead of the ordered 10 units of insulin.</p> <p>On 12/7/13 at 11:00 a.m. the blood sugar was 397 and received 8 units instead of the ordered 10 units.</p> <p>On 12/7/13 at 4:00 p.m. the blood sugar was 470. The Physician's Order dated 12/7/13 at 4:00 p.m. indicated</p>						

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	<p>1. give Humalog insulin 15 units now for a blood sugar of 470.</p> <p>2. Start Lantus insulin and administer 20 units every night at bedtime.</p> <p>On 12/7/13 at 8:00 p.m. the resident's blood sugar was 512. Physician's Order dated 12/7/13 at 7:00 p.m. indicated</p> <p>1. give Humalog insulin 20 units now for a blood sugar of 512.</p> <p>2. Increase the dosage of Lantus insulin from 20 units to 60 units administer every morning and every evening.</p> <p>On 12/8/13 at 4:00 p.m. the resident's blood sugar was 385 and received Humalog insulin 8 units instead of the ordered 10 units.</p> <p>On 12/8/13 at 8:00 p.m. the resident's blood sugar result was 417. The Physician's order dated 12/8/13 indicated give Humalog insulin 10 units now for blood sugar of 417.</p> <p>On 1/2/14 the Physician's Order for the sliding scale coverage for insulin was clarified by LPN #7 and indicated if the blood sugar results are 301-350 give 8 units, and if the blood sugar results are 351-400 give</p>						

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	<p>10 units of insulin.</p> <p>The Nurses Notes dated on 1/2/14 indicated there was no documentation Resident #88's Physician was notified, of the medication error, in regard to the incorrect dosage of the sliding scale insulin coverage from 12/5/13 through 1/2/14.</p> <p>On 1/30/14 at 11:00 a.m. an interview with the Director Nursing Service (DNS) indicated on 1/2/14 LPN #7 had called Resident #88's Physician and clarified the sliding scale insulin coverage order. The DNS indicated LPN #7 should had documented she called the resident's Physician and clarified the sliding scale insulin coverage.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				