

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155490	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2013
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NAME OF PROVIDER OR SUPPLIER  AMBASSADOR HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 705 E MAIN ST CENTERVILLE, IN 47330
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F000000	<p>This visit was for the Investigation of Complaint IN00129971.</p> <p>Complaint IN00129971 - Substantiated. Federal/state deficiency related to the allegation is cited at F309.</p> <p>Survey dates: June 11 and 12, 2013</p> <p>Facility number: 000456 Provider number: 155490 AIM number: 100288750</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: SNF: 4 SNF/NF: 104 Total: 108</p> <p>Census payor type: Medicare: 26 Medicaid: 70 Other: 12 Total: 108</p> <p>Sample: 3</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>By submitting ther enclosed materials we are not admitting the turth or accuracy of any specific findings or allegations as of any proceedings and submit these responses pursuant to our regulatory obligations. We ask that you consider this 2567 for a desk review.</p>	
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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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	Quality review 6/17/13 by Suzanne Williams, RN			

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F000309 SS=E	<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 observation, interview and record review, the facility failed to ensure diabetic care of performance of blood glucose testing, administration of physician ordered insulin, follow up of elevated laboratory levels of testing and routine documentation of dietary intake, related to the diabetes, were conducted for 3 of 3 residents reviewed for diabetic care in a sample of 3. (Resident #A, #B, and #C)</p> <p>Findings include:</p> <p>1. Resident #A's clinical record was reviewed on 6-11-13 at 11:46 a.m. His diagnoses included, but were not limited to, diabetes, high blood pressure, coronary artery disease, elevated lipids (fats found in the blood), and history of TIA (transient ischemic accidents or mini-strokes) and CVA (cerebral vascular accident or stroke).</p> <p>Review of the resident's physician's</p>	F000309	<p>F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING I. Resident #A no longer resides at the facility. Resident #B recap was corrected to include the regular diet order. Resident #C doctor was notified of the missed A1C lab. Doctor ordered A1C on 6-13-2013, it was drawn on 6-14-2013 and physician was notified of the results with no new orders. The A1C was 9.2 which is much improved. Residents' #B and #C did receive insulin, blood sugars, and meals as ordered but they were not signed off. No negative outcome. Nurses, QMA's, and C.N.A.'s were educated on the importance of documentation. II. Current residents residing in the facility who receive insulin and blood sugars had clinical record reviews to ensure residents are receiving blood sugars and insulin per physician order and plan of care. All these residents' MAR's, TAR's, and ADL's have been reviewed for holes. Nurses, QMA's, and C.N.A.'s were educated on the importance of</p>	07/12/2013	

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	<p>orders indicated he was to receive Lantus (type of long-acting insulin), a continuing order, 26 units each morning subcutaneously until it was discontinued on 5-8-13. Upon discontinuation of this insulin order, he was ordered to receive Levemir Insulin 26 units each morning subcutaneously. He also was to receive Humalog (a fast-acting insulin) 5 units subcutaneously three times daily within 15 minutes of each meal. The physician order for this medication indicated to administer 1/2 of the dose if the resident ate 1/2 of his meal.</p> <p>Additionally, he was to receive a sliding scale dosage of Humalog (a fast-acting insulin), based on the results of his blood glucose (BG) results. The sliding scale prior to each meal indicated to administer the following subcutaneously: no insulin for BG of under 151; for BG 151-200, 2 units; for BG 201-250, 4 units; for BG 251-300, 6 units; for BG 301-350, 8 units; for BG 351-400, 10 units; for BG over 400, 12 units. A second sliding scale for bedtime, also using Humalog insulin, indicated to administer the following: for BG under 251, no insulin; for BG 251-300, 2 units; 301-350, 4 units; 351-400, 6 units; for BG over 400, 8 units. The physician orders indicated</p>		<p>documentation. All residents with current A1C orders were identified. These residents had current lab orders verified and all lab tests provided as per order and plan of care. All current residents residing in the facility had clinical record reviews to ensure residents' diet orders were correct and no other diet orders were missed on the re-writes. III. A systemic change includes the Director of Nurses and/or administrative staff is to obtain caretracker report titled, "Missed observations." Reports are to be reviewed with staff nurses and C.N.A.'s to ensure all paperwork is completed on paper when missed on the computer. Training will be provided to all nursing staff on the protocol for the caretracker and on the importance of documenting the blood sugars, insulin's, and meal intakes. The systemic changes includes that new physician orders including admission orders will be reviewed daily (Monday through Friday) by the Director of Nurses and/or administrative staff and any orders for A1C will be identified to ensure routine A1C levels are monitored as per order and plan of care. The Director of Nurses will receive a copy of all new diet orders to ensure they get on re-writes. Training will be provided to all licensed staff for the process and importance of new orders including labs and diet orders, taking off order</p>				

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	<p>to notify the physician and daughter for BG under 60 and over 450.</p> <p>Review of the MAR (Medication Administration Record) indicated for April, 2013, the following occurred:</p> <ul style="list-style-type: none"> <li>- of 30 possible doses of Lantus insulin for April, 2013, 2 were not indicated as administered.</li> <li>- of 120 possible blood glucose levels to be obtained, 13 were not indicated as obtained.</li> <li>- of 90 possible doses of the three times daily Humalog, 14 were not indicated as administered.</li> <li>- of 120 possible sliding scale insulin doses of Humalog, 17 times there were no indication of either the blood glucose result and/or the amount of insulin administered to the resident.</li> <li>- of 90 possible doses of the three times daily Humalog, none indicated the percentage of meal intake or if a full dose or 1/2 dose was administered.</li> <li>- of 90 possible meal intake records for April, 2013, 24 meal intakes were not indicated to be documented.</li> </ul> <p>Review of the MAR (Medication Administration Record) indicated for May, 2013, the following occurred:</p> <ul style="list-style-type: none"> <li>- 2 of 8 doses of Lantus were not indicated as administered.</li> <li>- of 105 possible blood glucose</li> </ul>		<p>process and getting transferred to the re-writes. IV. The Director of Nurses and/or administrative staff will monitor the residents who receive insulin and/or blood sugars and meal intake 5 times a week for 1 month and then to monitor 5 times a month for an additional 5 months. The Director of Nurses and/or administrative staff will provide a clinical record review of residents with A1C orders for 6 months. This review will include routine A1C levels are monitored and all lab tests are provided as per order and plan of care. The Director of Nurses and/or administrative staff will review each new diet order and ensure it is on the re-writes. This will be on-going. Any identified concerns will be addressed immediately. The results of these audits will be discussed at the facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Completion Date: July 12, 2013</p>				

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	<p>levels to be obtained, 26 were not indicated as obtained.</p> <ul style="list-style-type: none"> <li>- of 79 possible doses of the three times daily Humalog, 15 were not indicated as administered.</li> <li>- of 105 possible sliding scale insulin doses of Humalog, 37 times there were no indication of either the blood glucose result and/or the amount of insulin administered to the resident.</li> <li>- of 79 possible doses of the three times daily Humalog, none indicated the percentage of meal intake or if a full dose or 1/2 dose was administered.</li> <li>- of 79 possible meal intake records, 17 meal intakes were not indicated documented.</li> <li>- a breakfast intake of 25% on 5-1-13 was indicated. The MAR indicated the resident received a dose of the routine Humalog insulin, but did not indicate if it was a full or partial dose. The BG for this meal was indicated as 206 and indicated he received 4 units of Humalog insulin</li> <li>- on 5-14-13, the supper meal intake was indicated as 0%. The MAR indicated the resident received a dose of the routine Humalog insulin, but did not indicate if it was a full or partial dose. The BG for this meal was not indicated. The MAR indicated the sliding scale Humalog for this meal with the staff members initials which</li> </ul>						

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	<p>were circled which typically indicates the medication was not administered.</p> <ul style="list-style-type: none"> <li>- on 5-17-13, the supper meal intake was indicated as 0%. The MAR indicated the routine Humalog insulin with the staff member's initials which were circled which typically indicates the medication was not administered. The BG for this meal was indicated as 206 or 256. The MAR did not indicate what dosage of the sliding scale insulin the resident received.</li> <li>- on 5-25-13, the supper meal intake was indicated as 0%. The MAR indicated the resident received a dose of the routine Humalog insulin, but did not indicate if it was a full or partial dose. The BG for this meal was not indicated. The MAR did not indicate what dosage of the sliding scale insulin the resident received as it was blank.</li> <li>- on 5-26-13, the supper meal intake was indicated as 0%. The MAR indicated a blank entry for the dose of the routine Humalog insulin. The BG for this meal was indicated as 79. The MAR did not indicate what dosage of the sliding scale insulin the resident received as it was blank. Corresponding nurse progress notes did not indicate any notation regarding the BG or medications.</li> </ul> <p>In interview with LPN #1 on 6-12-13</p>			

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	<p>at 11:20 a.m., she indicated she felt sure the blood sugars and medications were conducted as ordered. "We were very particular about checking the blood sugars, because of his history with the ups and downs." She indicated, "I know his MARS look terrible...it makes us look bad...as the saying goes, 'If you didn't chart it, it wasn't done.'"</p> <p>A physician's order, dated 11-14-10, indicated laboratory tests of a basic metabolic panel and hemoglobin A1C (a test used with diabetes) were to be obtained every 3 months in February, May, August and November. There were no test results available in the clinical record for February, 2013 for these ordered laboratory tests. In interview with the Director of Nursing on 6-12-13 at 1:45 p.m., she indicated she also could not locate the test results.</p> <p>2. The clinical record of Resident #B was reviewed on 6-11-13 at 10:57 a.m. His diagnoses included, but were not limited to, diabetes, high blood pressure, elevated lipids, and CVA with left sided weakness.</p> <p>Resident #B was physician ordered to received blood glucose (BG) testing on Monday and Thursday at 6:00</p>						

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	<p>a.m., on Tuesday and Friday at 11:00 a.m., on Wednesday and Saturday at 4:00 p.m. and on Sunday at 9:00 p.m.</p> <p>Review of the MAR (medication administration record) indicated in April, 2013, 7 of 30 BG results were blank. 21 of 30 BG results indicated the resident refused BG testing. 2 of 2 BG results documented as obtained did not include the numerical value.</p> <p>Review of the May, 2013 MAR indicated 10 of 32 (sic) BG results were blank. 19 of 32 (sic) BG results indicated the resident refused the BG testing. 3 of 3 BG results indicated the numerical value of the BG testing.</p> <p>Review of the June, 2013 MAR indicated 11 of 11 BG results indicated the resident refused BG testing.</p> <p>Review of Resident #B's dietary notes indicated on 3-8-13, the Registered Dietitian recommended a change in diet from a diabetic, low sodium, low cholesterol diet to a regular diet. This recommendation was signed by the physician on 3-12-13. A written physician's note was not located in the clinical record. Review of the monthly recapitulation orders for April,</p>			

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	<p>May and June, 2013 indicated he was still ordered to receive the previous diet of a diabetic, low sodium, low cholesterol diet. In interview with the Dietary Manager on 6-11-13 at 2:17 p.m., she indicated the dietary change was recommended, "Because he was pretty stable and it was more what he preferred [to eat.]" The dietary manager provided a copy of the resident's dietary meal slip for 6-11-13 which indicated "Regular" diet. In interview with Resident #B on 6-11-13 at 11:45 a.m., he indicated the food was fine and he had no complaints with the food. Observation of Resident #B's meal intake at this time indicated he had consumed 75% of his lunch.</p> <p>Review of Resident #B's meal intake records for April, 2013 indicated 34 of 90 possible meals were not documented. Meal intake records for May, 2013 indicated 20 of 93 possible meals were not documented. Meal intake records for June, 2013 indicated 12 of 33 possible meals were not documented.</p> <p>3. Resident #C's clinical record was reviewed on 6-11-13 at 2:37 p.m. His diagnoses included, but were not limited to diabetes, poly-substance abuse and dementia.</p>						

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	<p>Review of the laboratory results, dated 12-5-12, indicated a grossly elevated hemoglobin A1C of 17.4% with a repeat of this test for confirmation on 12-7-12 of greater than 18% (normal range is under 5.7%). Review of the lab sheets for these dates indicated the physician was notified of the results by the facility.</p> <p>The physician progress notes for 12-11-12 indicated he visited with the resident on this date related to elevated blood sugars. Notes indicated, "I have never seen an A1C that high." It indicated he had made adjustments to the resident's insulin orders and "very likely will need to titrate him again...His A1C will need to be followed...hopefully we can get him down closer to his goal within the next six months." A physician progress note, dated 12-17-12, indicated he planned to have a repeat A1C test conducted in February, 2013. A physician progress note, dated 1-23-13, referenced the previously elevated A1C from December, 2012 of 17.4. It indicated the test "should be due to be checked again in another month or two." A progress note, dated 3-4-13, indicated a reference to the elevated</p>				

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	<p>A1C reading of December, 2012. It indicated the resident was due for other laboratory testing the following month. A progress note, dated 3-12-13, again referenced the elevated A1C reading of December, 2012. Progress notes, dated 4-2-13 and 5-17-13, did not address the elevated A1C.</p> <p>In interview with the attending physician on 6-12-13 at 12:40 p.m., he indicated he had mentioned in his progress notes the plan to repeat the A1C in 3 months, but never wrote the order to obtain the test. He indicated, "That was strictly an oversight on my part." He indicated, "I don't expect the [facility] nurses to review my progress notes to see what my plans are to to call me to verify everything. I should have written that order for the labwork."</p> <p>Review of Resident #C's meal intake records for April, 2013 indicated 2 of 90 possible meals were not documented.</p> <p>On 6-12-13, the Director of Nursing provided a copy of a policy entitled, "Physician Orders-Obtaining and Processing." This policy was indicated as the current policy. It indicated "All physician orders shall</p>			

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	<p>be recorded on the Physician Order form for each resident unless it is a faxed order...New orders are placed above the last physician's re-write."</p> <p>On 6-12-13, the Director of Nursing provided a copy of a policy entitled, "Medication Administration." This policy was indicated as the current policy. It indicated "If a resident refuses to take a medication, indicate on administration record in nurse's notes...Inform resident of possible consequences of refusal. Notify family or responsible party...Document on Medication Record: medication, dose, time give, refusal, signature (initials), include pertinent observations in nurse's notes."</p> <p>On 6-12-13, "Standards of Care for People with Diabetes," was retrieved from the American Diabetes Association website. This information indicated A1C testing should be conducted every 3 to 6 months.</p> <p>This Federal tag relates to Complaint IN00129971.</p> <p>3.1-37(a)</p>			