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	145363	A. BUILDING ______ B. WING ______	C 10/20/2005

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MANORCARE AT OAK LAWN/KOSTNER	**9401 SOUTH KOSTNER AVENUE OAK LAWN, IL 60453**

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F 309	Continued From page 11 2. The Director of Nurses has reviewed and validated that all resident MAR's pertaining to ACCU-CHEKs and any abnormal ACCU-CHEK values have had the appropriate interventions taken. 3. Nursing staff will verify ACCU-CHEK and insulin administration utilizing a two-person check . This process began 10/18/05. 4. Physicians will be notified of any abnormal ACCU-CHEK readings per protocol. 5. The Director of Nurses or designee will review random records of residents with diabetes requiring ACCU-CHEKs for proper documentation and physician notification. Issues regarding ACCU-CHEK follow-up will be corrected immediately. Trends will be discussed during Quality Assurance meetings until resolution of the issue occurs.	F 309		
F9999	FINAL OBSERVATIONS STATE VIOLATIONS ASSOCIATED WITH COMPLAINT # 0594352 300.610 a) 300.1010 h) 300.1210 a) 300.1210 b) 300.1210b)1) 300.1210b)2) 300.1210b)3) 300.1810g) 300.1810h) 300.3240 a) The facility shall have written policies and procedures, governing all services provided by	F9999		

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OMB NO. 0938-0391

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F9999	Continued From page 12 the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician, or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder . These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Facility staff shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:	F9999		

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F9999	Continued From page 13 Medications including oral, rectal, hypodermic, intravenous, and imtramuscular shall be properly administered. All treatments and procedures shall be administered as ordered by the physician. Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. A medication administration record shall be maintained, which contains the date and time each medication is given, name of drug, dosage, and by whom administered. Treatment sheets shall be maintained recording all resident care procedures ordered by each resident's attending physician. Physician ordered procedures that shall be recorded include, but are not limited to, the prevention and treatment of decubitus ulcers, weight monitoring to determine a resident's weight loss or gain, catheter/ostomy care, blood pressure monitoring, and fluid intake and output. An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations are not met based on staff interview and record review which revealed that: [1] The facility neglected R3 by failing to provide necessary services over a period of several days to avoid physical harm as evidenced by:	F9999		

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F9999	Continued From page 14	F9999		

[2] The facility failed to provide necessary care and services in accordance with plan of care for R3 as evidenced by:
[a] Failure to consult physician for elevated blood sugar
[b] Failure to administer insulin as ordered
[c] Failure to follow facility policy regarding treatment for hyperglycemia
[d] Failure to provide an ongoing nursing assessment
[e] Failure to follow manufacturers' guidelines for the use of their blood glucose monitoring system.
Resident had previous elevated blood sugars that were not monitored and insulin that was not given which resulted in a change of condition that was identified while the resident was at a medical visit away from the facility and which required a hospital admission due to the unmonitored and high blood sugar level.

Findings Include:

R3 was admitted to the facility on 09/19/05 because of fracture to ankle. Diagnoses include Alzheimer disease and Diabetes mellitus type II. R3 had ankle surgery on 09/26/05 and was readmitted to facility on 09/27/05. At time of readmission, physician ordered blood glucose monitoring to be done twice daily (6AM & 4PM) and Metformin hydrochloride 500mg. daily at 8 AM

Medication Administration Record (MAR) lists blood glucose monitoring results as follows:

10/01/05:
6AM blood glucose 222 mg/dl.

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F9999	Continued From page 15	F9999		

4PM - 256 mg/dl.

10/02/05:
6AM blood glucose 190 mg/dl.
4PM result not documented on MAR or in medical record.

10/03/05 6AM blood glucose 212 mg/dl.
4PM result not documented on MAR or in medical record.

10/04/05:
6AM blood glucose 176 mg/dl.
4PM - 549 mg/dl.

10/05/05:
6AM blood glucose 220 mg/dl.
4PM result documented as 'Hi' (over 550 mg/dl). Physician was called and ordered 12 units of regular insulin now and 30 units of Humulin 70/30 insulin in the morning at 6AM. R3 did receive the 12 units at 5PM and at 9PM blood glucose 292 mg/dl.

10/06/05:
6AM blood glucose 117 mg/dl.
There is no documentation R3 received 30 units of 70/30 Humulin at 6AM as ordered by physician the evening of 10/05/05.

Manufacturer guidelines for the blood glucose monitoring system used by this facility state: 'if the test result is above 550 mg/dl the meter will display " Hi". If this message appears, repeat the test procedure. If this message appears again, contact your physician immediately.' There is no evidence these guidelines were followed.

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F9999	Continued From page 16	F9999		

Facility policy titled 'Hyperglycemia Treatment' includes symptoms of hyperglycemia (Blood sugars over 400 mg/dl or above), and procedures which include: notify Physician immediately, monitor vital signs every 5-15 minutes, assess clinical status, monitor blood glucose every 15 minutes until results within normal limits for resident, verify physician orders, administer insulin as ordered, be prepared to activate EMS (emergency medical services) and transport if condition deteriorates or does not improve.

A nurses note, dated 10/06/05 at 1PM, states R3 alert and up in wheelchair. Appetite not quite as good since getting pain meds. Medicated times two this shift due to facial grimacing. More lethargic with increase in amount given. Family has not shown up for appointment.
At 1:35PM medi-car here to transport R3 to doctor appointment. Resident up in wheelchair and noted awake.

Review of nurse's notes dated 9/28/05, 10/4/05, 10/05/05 and 10/06/05 do not contain any discussion of elevated blood sugars or further assessments of R3. Record contained no evidence of retesting resident's blood glucose levels as specified by manufactures recommendations or monitoring of R3 as stated in facility policy/procedure for treatment of hyperglycemia.

During interview on 10/18/05 Z1 stated she met R3 at the doctor's appointment and she found R3 to be unresponsive and she called the paramedics. Z1 stated the paramedics gave R3 some shot because of concern of over sedation

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F9999	Continued From page 17	F9999		

as a result of pain medication. Z1 also stated R3's blood sugar was over 500.

Emergency Room (ER) records for R3 and dated 10/06/05 were reviewed and state, under the history of present illness: 'Per granddaughter, patient doing well since surgery but this AM she found patient unresponsive, slumped over in chair, eyes closed, shaking. Rehab facility claims patient was 'fine' when she left and the only thing that was new today was that the patient received and an extra Vicodin for pain. Patient was given Narcan in the ambulance with no improvement. On admission, patient is shaking, mildly responsive, became hypotensive with systolic blood pressure 60's and responsive to fluids. Also with glucose over 500.'

Laboratory results in the ER shows glucose as 560mg/dl and white blood cell count as 21.3. Assessment/plan states R3 in guarded condition. Initial physical exam lists diagnoses as dehydration, hyperglycemia, leukocytosis improved with fluids and insulin. R3 was subsequently admitted to the hospital.

During interview on 10/19/05 E1, Administrator, stated that she had spoken to E3; the nurse from 10/02/05, on 10/18/05. E3 remembers the 4PM blood to be "somewhere in the 200's". E3 confirmed she did not document the results of the blood glucose monitoring.
E1 also stated that she had spoken to E4, staff nurse on 10/03/05; E4 remembers the 4PM blood glucose as 'Hi' but did not document the results. A physician order was obtained for 10 units of regular insulin that R3 received at 6PM.

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F9999	Continued From page 18 During interview on 10/19/05 with E2, Director of Nurses, stated facility's blood glucose monitor reads 'Hi' for blood sugars over 550mg/dl. Record contained no further monitoring of R3 after the insulin was given. E6 is documented as the nurse completing the 4PM blood glucose monitoring on 10/04/05. Medical record contained no further assessment of R3. E6 was interviewed on 10/18/05 approximately 1PM and stated she was nurse on duty 10/04/05 and her initials are on MAR as completing 4PM blood glucose monitoring. E6 stated she does not remember the blood sugar of 549. E6 was asked what should have been done if a resident has a blood sugar of 549 and E6 stated the physician should have been called and resident monitored. Record contained no documentation of monitoring of R3 with a blood sugar of 549mg/dl. Z2, Physician, was interviewed at 5:30PM on 10/18/05 and stated he should have been made aware of R3's blood sugar of 549 on 10/04/05. During interview on 10/19/05 E1, stated she had spoken to E5, nurse on duty in the AM of 10/06/05 who stated she did not remember if R3 received insulin or not. (A)	F9999		