

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/12/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145607	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/20/2006
NAME OF PROVIDER OR SUPPLIER MANORCARE AT PALOS HEIGHTS			STREET ADDRESS, CITY, STATE, ZIP CODE 7850 WEST COLLEGE DRIVE PALOS HEIGHTS, IL 60463		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 6	F 309			
F9999	<p>proficiency on Insulin Pump prior to admission of resident with Insulin Pump.</p> <p>FINAL OBSERVATIONS</p> <p>STATE LICENSURE VIOLATIONS:</p> <p>Section 300.1010 Medical Care Policies</p> <p>h) The facility 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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological 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. Restorative measures shall include at a minimum the following procedures:</p>	F9999			

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F9999	Continued From page 7 b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 1) Medications including oral, rectal, hypodermic, intravenous and intramuscular shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.1610 Medication Policies and Procedures a) Development of Medication Policies 1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws. 2) Medication policies and procedures shall be developed with the advice of a pharmaceutical advisory committee that includes at least one licensed pharmacist, one physician, the administrator and the director of nursing. This committee shall meet at least quarterly. e) The staff pharmacist or consultant pharmacist shall participate in the planned in-service education program of the facility on topics related	F9999			

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F9999	<p>Continued From page 8 to pharmaceutical service.</p> <p>Section 300.3220 Medical and Personal Care Program</p> <p>f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's Director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)</p> <p>These REGULATIONS are not met as evidenced by:</p> <p>Based on record review and interview of staff and others, the facility failed to provide the necessary treatment and services over a period of two months to avoid physical harm as evidenced by:</p> <ol style="list-style-type: none"> 1) Failure to notify physician in a timely manner regarding very high blood sugars. 2.) Failure to administer insulin as ordered. 3) Failure to provide timely nursing assessments 4) Failure to place policy and procedure for the use of Insulin Pump. 5) Failure to obtain specific Insulin pump dose order from an authorized licensed person. 6) Failure to provide proper inservices to properly care for R3 using an insulin pump. <p>These failure resulted in R3's alarmingly high blood sugars. These elevated sugars were not addressed appropriately and timely. R3 ended</p>	F9999			

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F9999	<p>Continued From page 9 up in the hospital with a diagnosis of Diabetic Keto-acidosis on 12-24-05 and has been in the hospital since.</p> <p>Findings include:</p> <p>R3 was admitted to the facility with a diagnoses that included Insulin dependent Diabetes Mellitus . Orders included sliding scale insulin coverage that included notification of MD for glucose above 400 or below 100.</p> <p>On 10-17-05 11 PM, nurses note documented, " Blood sugar 228 @ dinner-1.6 u bolus Novalog given. Daughter inserviced Nursing today on Insulin pump." There was no order for placement of insulin pump nor parameters for the Insulin dose. The facility followed R3's daughter's parameters on the pump. On 10-18-05, nurses note at 1:15 PM reflect "Called Dr. Tang and informed of BS this AM (56) and noon (66). Informed MD, daughter hooked R3 back on Insulin pump. New orders received. Called daughter regarding BS to update." The order written denotes " May start insulin pump. Follow what the daughter sets for Bolus rate/Basal rate." Review of record indicated that there was no order to put back the pump nor did the staff consult with R3's MD, Z1, prior to allowing placement of the pump. The pump started providing basal rate insulin on a continuous basis without Doctor's order on 10-17-05. Record also indicate that R3's daughter was not a doctor or legal delegate to initiate insulin pump or provide the facility with the Insulin basal rate and bolus rate.</p> <p>The facility could not explain where the daughter</p>	F9999			

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F9999	<p>Continued From page 10</p> <p>obtained parameters, but E3 and E4 indicated that the daughter could be related to the company supplying the Pump. There are no original orders for the dosages, and facility staff wrote Insulin basal rate and bolus calculations based on what the daughter set on the insulin pump. Facility did not have any policy and procedure on the use of Insulin pump. Facility could only show brochures on the use of the pump for pain management. The daughter gave the facility inservice on the pump, but there was no documentation in the facility on who received this inservice.</p> <p>Original order for R3's Accuchecks on admission was for 6 AM and 4 PM with sliding scale coverage, call MD above 400 blood sugar or below 100. This was later changed to every 4 hours on 10-18-05 then to four times a day on 11/05. Parameters to notify MD were changed to show to notify MD if blood sugar is lower than 70. Above abnormal parameters (blood sugar over 400) for MD notification was not changed nor discontinued. Review of R1-R7 show the same parameters for MD notification for any blood sugar above 400.</p> <p>On 12-23-05, R3's blood glucose at 12 PM was 497 and 4 PM was 524. (70-110 IS NORMAL) The Doctor was not notified after each of these very high blood glucose were noted. The 8 PM glucose result was "hi" indicating the blood sugar was higher than 600. MD was paged and responded at 11:15 PM. The facility did not address the high blood glucose at 8 PM nor provide any coverage for this alarmingly high blood sugar. R3 started vomiting at 8:45 PM, at 10:45 PM, and 11:45 PM.</p>	F9999			

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F9999	Continued From page 11 Interview of E6 and E7 reflected that after each very high blood sugar were done, the Insulin Pump was not checked for proper placement and functioning. The pump was not checked if there was enough Insulin in the cartridge. Both E6 and E7 acknowledged that MD was not notified with the explanation that the bolus rate order did not specify notification for abnormal blood glucose that are high. Both acknowledge that normally they would notify the MD for blood sugar above 400. Review of orders for R1 to R7 show all these resident have orders for Accuchecks and specified to call MD for blood sugar above 400. On interview, Z1 indicated that he does not remember whether he had ordered any insulin coverage when he called back 12-23-05 but indicated that he was not called for the other blood sugar that was high. Z1 also stated that the facility would call him for any blood sugar 400 and above. R3 had to be sent to hospital at 2:30 AM with blood pressure going down and vomiting 5 times. R3 was admitted to the hospital where she was diagnosed with Diabetic Ketoacidosis. Blood glucose was 897, blood Bicarbonate was 9.7 (normal of 20 to 24), and Blood PH of 7.19 (7.35 to 7.45)	F9999			