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F 333	Continued From page 21 will be corrected immediately, and will be reported to QI committee for follow up. d). The Medical Director was notified of the incident on 2/16/07. e). E5 was suspended during the incident investigation and terminated on 2/20/07.	F 333		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION 300.610a) 300.1010h) 300.1210a) 300.1210b)1) 300.1610a)1) 300.1620a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by 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. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a	F9999		

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F9999	Continued From page 22 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. Section 300.1210 General Requirements for Nursing and Personal Care 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. b)1) Medications including oral, rectal, hypodermic, intravenous and intramuscular shall be properly administered. Section 300.1610 Medication Policies and Procedures a)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. Section 300.1620 Compliance with Licensed Prescriber's Orders	F9999		

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F9999	Continued From page 23 a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time. These regulations are not met, as evidenced by the following: Based on record review and interview the facility failed to notify the physician of a significant medication error for 1 (R1) of 5 sampled residents receiving insulin. On 2/12/07 R1 was administered 107 units of sliding scale regular insulin at 5:00 PM and 9:00 PM with no physician order for sliding scale insulin. The attending physican and hospital physican were notified of only one administration of 107 units of regular sliding scale insulin. This failure resulted in delay in treatment for R1. R1 became hypoglycemic and hypotensive with admission on 2/13/07 to the hospital intensive care unit. The findings include: 1. R1 was admitted to the facility on 2/8/07 with diagnoses, in part, of Type 2 Diabetes Mellitus, status post knee replacement with Methicillin Resistant Staph Aureus in the surgical site, congestive heart failure, and hypertension. On admission to the facility from the hospital, R1 had physician orders for Regular Novolin Insulin	F9999		

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F9999	Continued From page 24 U-100 sliding scale. On 2/10/07 the "Physician Order Sheet" clarified the order as follows: "Reg insulin per S/S (sliding scale) less (than) 125-0 u, 126-150- 2 u, 151-200-4 u, 201-250-6 u, 251-300-8 u, 301-350-10 u Call if greater than 350 blood sugar." On 2/12/07 R1 went to the physician office of Z1. R1 saw Z2, Nurse Practitioner, during that visit. In an interview on 2/22/07 at 9:00 AM by phone, Z2 stated she did see R1 at the physician office and hand wrote orders for R1 to take back to the facility. Z2 wrote the orders on a "Physician Progress Notes" with Z1 and Z2's name under the physician name. The orders stated "Insulin 70/30 62 units 2 x's/day (pt can titrate)." Z2 stated she had changed this insulin order and had not written an order for sliding scale insulin. Z2 stated Z1 had called the facility after that order and had ordered sliding scale insulin at lunch time only. In an interview with Z1, Physician, on 2/20/07 at 3:10 PM, he stated that R1 should have had orders for sliding scale insulin at lunch only. Z1 stated they had changed his insulin back to the 70/30 insulin. The "Physician Progress Notes" with the medication list was present in R1's medical record and was also transcribed as written by Z2 to the "Physician Order Sheet" dated 2/12/07. The "Medication Record" has documented "Insulin 70/30 62 units 2 xs a day" with the time of 800 AM and 1700 (5:00 PM) listed as the time to give the insulin. There were no orders on the POS from the physician visit for sliding scale insulin. There were no orders on the POS for the sliding scale insulin at lunch only. On 2/12/07 there is no documentation that the 62 units of 70/30 insulin were administered at the 5:00 PM time.	F9999		

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F9999	Continued From page 25 The "Medication Record" for the sliding scale Regular Insulin does document that at 1700 hours on 2/12/07 the blood sugar was checked and found to be 325. To the side of the blood sugar value is written "107 u." At 2100 hours the blood sugar was checked again and found to be 349. There is no documentation that any insulin was given at that time, however E5, Licensed practical Nurse, confirmed that 107 units of sliding scale regular insulin was given again at 9:00 PM on 2/12/07. In an interview with E5, Licensed Practical Nurse, on 2/20/07 at 1:15 PM by phone, he stated that R1 returned from the doctor on 2/12/07. E5 was working the 3:00 PM to 11:00 PM shift on 2/12/07. E5 stated R1's family was upset about the medications not arriving from the hospital so he was rushing to make that family member happy. E5 stated he took the blood sugar reading at 1700 hours and the sugar was over 300 so he gave R1 107 units of the regular sliding scale insulin. E5 stated he took the blood sugar again at 9:00 PM and it was higher so he gave the 107 units of regular sliding scale insulin again. E5 stated R1 did have an order for sliding scale insulin. E5 stated he misread the order and thought the 10 units was 107 units. E5 stated that R1 "should have crashed with that much insulin but didn't so I gave the second dose." E5 stated he did not clarify the insulin orders with the physician even though he did clarify other orders. E5 confirmed that he did not give the 70/30 Insulin of 62 units at 5:00 PM as ordered by the physician. E5 stated he did not check R1's blood sugar level after he gave the insulin at 9:00 PM but did check on R1 about 10:30 PM and he was fine-lucid. E5 stated he did not tell the oncoming Registered Nurse, E4, that he had given the 107	F9999		

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F9999	Continued From page 26 units of regular insulin at 5:00 and 9:00 PM. E5 stated he did tell E4 that the blood sugars had been high. According to the nurses notes dated 2/13/07 at 12:55 AM, R1 was found "very diaphoretic et (and) slow to respond Took (blood sugar monitor) 33-2 cans of OJ given one with 2 packs of sugar." Again at 6:30 AM R1 was diaphoretic with the (blood sugar monitor) at 37. Glucagon was ordered by the physician and had to be given twice to increase R1's blood sugar. R1 also received glucagon at 12:40 PM and 1:05 PM due to low blood sugar. At 3:00 PM R1 was again diaphoretic with oxygen saturation levels at 75%. Oxygen was applied at 10 liters. The physician was called and R1 was sent to the emergency room where he was admitted with the diagnosis of hypoglycemia and hypotension. In an interview with E4, Registered Nurse on 2/20/07 at 1:15 PM by phone, E4 stated she came into work 11:00 PM on 2/12/07 and stayed til 2:00 or so on 2/13/07 due to the weather. E4 stated E5 had not told her he gave 2 doses of insulin. E4 stated she fought all night to keep R1's blood sugar up. E4 stated she looked at the med sheet and saw he had given 104 units of regular insulin. E4 stated she wasn't sure how someone would think the units had gone from 8 to 100 on the sliding scale doses instead of 10. E4 stated she did call the physician and told him R1 had had one dose of 104 units of Regular insulin. E4 stated she found out late morning on 2/13/07 that E5 had given the insulin dose twice. E4 stated she did not call the physician regarding the administration of the second dose of Regular insulin as she thought the other nursing staff had called. E4 confirmed that she could not find the	F9999		

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F9999	Continued From page 27 order to continue the sliding scale insulin in the chart. E4 stated R1 only had the order for the 62 units of 70/30 insulin. In an interview with E8, Licensed Practical Nurse, on 2/21/07 at 11:00 AM she stated that she became aware that R1 had received 2 doses of 107 units of sliding scale Regular insulin when E5 called her sometime after noon to report off for the evening due to the weather. E8 stated E5 informed her then that he had given two doses of 107 units of regular insulin. There is no time documented on the call off sheet. E8 stated she told E6 and E7, Licensed Practical Nurses, and E4 that R1 had received two doses. E8 stated she had not called the physician and thought that E6 may have. In an interview with E6, Licensed Practical Nurse, on 2/20/07 at 1:00 PM she stated E4 had told her when she came on duty that R1 had had problems with his blood sugar over night. E4 told her that R1's sugar had bottomed out and he had received glucagon. E6 stated E4 had talked to the physician over night about the low blood sugar. E6 stated she was not aware until afternoon that R1 had received two doses. In an interview on 2/21/07, E6 stated she had told Z2 that R1 had received two doses of insulin at 1340 PM when E8 had told her he had received the two doses. E6 stated Z1 was standing next to Z2 when she called and said to give protein and do blood sugar monitoring every hour. The clinic notes from Z2 identifies E6 as the caller. There is no documentation on the clinic or nurses notes that R1 received two doses of 107 units of regular insulin. In an interview with E7, Licensed Practical Nurse,	F9999		

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F9999	Continued From page 28 on 2/21/07 at 11:15 AM she stated she came in to work at 6:45 AM and E4 was taking care of R1. E4 told her in report that R1 had been given 107 units of regular insulin once. E7 said she became aware of the two doses of insulin given from E8. E7 stated E6 was dealing with the physician. E7 stated she had not talked to the physician or nurse practitioner regarding the insulin administration. E7 stated at 3:00 PM R1 became diaphoretic and the physician was called and R1 was sent to the hospital. In an interview by phone on 2/20/07, Z1, Physician, stated R1 had received 107 units of Regular insulin. Z1 stated he had not been told that R1 had received two 107 unit doses of regular insulin. Z1 stated he would have sent R1 to the hospital right away if he would have known that information. According to Z1, R1 spent 2 days in the intensive care unit as a result of the insulin administration which at the time he thought was 107 units of Regular insulin. Z1 stated during the interview that he had only been told of the one administration of 107 units of regular insulin and was not aware until this time that R1 had received a total of 214 units of regular insulin. In an interview with Z2, Nurse Practitioner, on 2/22/07 by phone, she stated she had not been told that R1 received two 107 unit doses of Regular sliding scale insulin. Z2 stated she was only aware of the one administration of 107 units of Regular insulin. Z2 stated that would have explained a lot if they would have known he got 214 units of Regular insulin instead of 107 units. Z2 stated R1 was not responding to what they were doing to keep his blood sugar up with the the glucagon administration and food. Z2 stated	F9999		

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F9999	Continued From page 29	F9999		

they would have given more sugar if they would have known. Z2 stated she was under the impression they had only given one dose of the 107 units. Z2 stated 214 units was a lot different than 107 units. Z2 stated Z1 was there with her at the clinic around noon when the facility staff called and told her R1's blood sugar was 50-60 and they were asking to give glucagon. Z2 stated Z1 said to check the blood sugar every hour.

Review of the chart note done by Z2 at the clinic when the facility called noted the time of 12:30 PM and 1:45 PM on 2/13/07. Z2 noted the blood sugar was 56 then 46 after given juice. Z2 gave the order for glucagon now and repeat one time if needed. At 1:45 PM Z2 documented that the 2 doses of glucagon had been done and the blood sugar was up to 63 after that. The clinic note states as recommendations to give R1 some protein with accuchecks every 1 hour and call if it is less than 70 per Z1. There is no documentation on the clinic notes or the facility nursing notes that Z1 or Z2 had been notified of the 2 doses of 107 units of regular insulin.

Review of the nursing notes for R1 from 2/12/07 until discharge to the hospital does not indicate R1 received 2 doses of 107 units of regular sliding scale insulin. Review of the "Medication Error Report" which was filled out by E4 does identify R1 received "Regular insulin 104 u Regular insulin given at 1700 and 2100." The report states Z1 was notified.

Review of the transfer sheet from the facility when R1 was sent to the hospital does not mention R1 received 214 units of insulin on 2/12/07. The transfer sheet states "BS 70 has

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F9999	Continued From page 30 dropped today." The hospital history and physical and emergency room report dated 2/13/07 states R1 was accidentally given 170 units of regular insulin last night at 1:00 AM. The source of the information was listed as family and patient. Review of the "Medication Errors and Drug Reactions" policy and procedure states a detailed account of the incident will be recorded in the residents medical record which includes: time and date of the incident, name, strength and dosage of the medication, condition of the resident, any treatment administered and the date and time the physician was notified and what instructions were given. It further states "All medication errors and drug reactions will be reported immediately to the Director of Nursing, the attending physician and the pharmacist and will be documented according to established procedures." (A)	F9999		