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W 381	Continued From page 37 at 4:20 P.M. and stated "We don't keep the insulin in a lock box in the refrigerator and the refrigerator doesn't lock." During this interview, E1 confirmed that R1's and R2's insulin medications are not kept in a separate, securely fastened locked box within the refrigerator or in a locked refrigerator.	W 381		
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 350.1210b) 350.1220j) 350.1230b)6) 350.1230e) 350.1410a) 350.1410d) 350.1420a) 350.1430d) 350.3240a) 350.3750 Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. These services include, but are not limited to, the following: b) Nursing services to provide immediate supervision of the health needs of each resident by a registered professional nurse or a licensed practical nurse, or the equivalent. Section 350.1220 Physician Services j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or	W9999		

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W9999	Continued From page 38 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. Section 350.1230 Nursing Services b) Residents shall be provided with nursing services, in accordance with their needs, which shall include, but are not limited to, the following: The DON shall participate in: 6) Development of a written plan for each resident to provide for nursing services as part of the total habilitation program. e) Sufficient, appropriately qualified nursing staff shall be available, which may include licensed practical nurses and other supporting personnel, to carry out the various nursing service activities. Section 350.1410 Medication Policies and Procedures a) 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. 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.	W9999		

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W9999	Continued From page 39 d) All medications administered shall be recorded as set forth in Section 350.1620. Medications shall not be recorded as having been administered prior to their actual administration to the resident. Section 350.1420 Compliance with Licensed Prescriber's Orders 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 350.1610. 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. Section 350.1430 Administration of Medication d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record. Section 350.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. Section 350.3750 Consultation Services and Nursing Services	W9999		

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W9999	Continued From page 40 Residents needing nursing care shall be admitted to an ICF/DD of 16 Beds or Less only if the facility has adequate professional nursing services to meet the resident's needs. Arrangements shall be made through formal contract for the services of a licensed nurse to visit as required. A responsible staff member shall be on duty at all times who is immediately accessible, and to whom residents can report injuries, symptoms of illness, and emergencies (see Section 350.810(a)). The consultant nurse shall provide consultation on the health aspects of the individual plan of care and shall be in the facility not less than two hours per month. These regulations are not met, as evidenced by the following: Based on interview and record review, the facility failed to provide diabetic monitoring necessary to meet the individual's needs for 1 of 1 individual (R1) in the sample receiving insulin on a sliding scale as based on her blood sugar readings. The facility has failed to ensure that: 1) Sufficient nursing staff are available to administer insulin injections to R1 based on her blood sugar readings which are to be completed four times daily as ordered by the physician; 2) Direct care staff completes R1's blood sugar readings prior to meals and at bedtime and that they document these reading to ensure that, if needed, insulin can be administered to R1 ; 3) Nursing staff administers R1's Novolin R in a timely manner and within thirty to sixty minutes	W9999		

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W9999	Continued From page 41 before a meal; 4) Medication error reports are completed as per the facility's policy and that nursing staff notifies the physician of the date(s) and time(s) that R1 did not receive her insulin and/or when she received her insulin four to fourteen hours late; 5) An individualized plan of care for diabetic monitoring, inclusive of parameters for nursing and physician notification is developed and implemented by nursing and direct care staff; 6) The physician (Z2) was notified of R1's elevated blood sugar reading of 418 on 11/25/11 as physician ordered when her blood sugar reading is above 400; 7) Nursing staff has a phone number to contact R1's physician (Z2) after normal office hours; 8) R1's physician orders for blood test for CMP (Comprehensive Metabolic Panel), CBC (Comprehensive Blood Count), Magnesium, A1c (Glycohemoglobin) and HGB (hemoglobin) are completed quarterly and that these results and R1's abnormal results are reported to the physician; 9) Ensure that a Registered Nurse is available for consultation and to provide necessary monitoring and oversight to staff for the delivery of nursing services. Findings include: The Blood Sugar monitoring sheets for R1 for November 2011, December 2011, January 2012,	W9999		

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and February 2012 identify that direct care staff do not always document R1's blood sugar reading four times daily as physician ordered. In comparing these monitoring sheets with R1's corresponding Medication Administration Records (MARs) for these months, it is identified that nursing staff failed to administer R1 her insulin injections and/or administered her insulin injections four to fourteen hours after her blood sugar reading was obtained. Medication errors were noted to occur seven times in November 2011, six times in December 2011 and nine times in January 2012. On 02/01/12 at 4:30 P.M., E4 (Direct Care staff) stated that the nurse (Z1) is not able to come to the facility before 8:00 P.M. and that a nurse is not available for the weekends to administer R1's insulin injection. In comparing the Blood Sugar monitoring sheets with R1's corresponding Medication Administration Records (MARs) for November 2011, December 2011 and January 2012 it is identified that the facility did not have available sufficient nursing staff to administer R1's Novolin injections to her on an as needed basis, four times daily. Nursing staff does not notify the physician when R1 does not receive her Novolin medication, nor does nursing staff notify the physician regarding R1's abnormal lab values.

No individualized plan of care has been developed to address R1's diabetic needs, nor have parameters for nursing and/or physician notification been established. The Administrator (E1) stated on 03/06/12 that the facility does not maintain a phone number to contact Z2 (R1's physician) after normal office hours. During a telephone interview with Z2 on 02/07/12 at 10:17 A.M., he stated that the current facility's practice

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of R1 not receiving her insulin, "jeopardizes her health." Z2 also stated, "If they (the facility) are not administering her insulin injections because a nurse is not available, they are not meeting and cannot meet her needs."

The Physician's Orders dated 02/01/12 states that R1 has diagnoses of Cellulitis, Psychosis, Mental Retardation (unspecified), Chronic Kidney Disease and HTN (Hypertension).

R1's undated Medical Care Plan(s) states that she has a problem with Diabetes and that she has a goal to maintain her blood sugars. Approaches within this plan include:

1) Assist client with consumption of blood sugar medication(s);
2) Assist client with following a 1500 calorie ADA diet;
3) Obtain blood sugar daily before each meal and @ (at) hs (bedtime);
4) Follow sliding scale insulin order for administration of insulin.

Further review of this medical plan does not include parameters as to when direct care staff are to notify nursing staff and/or when nursing staff are to notify the physician.

R1's Physician's Orders dated 02/01/12 states that she is to receive, "Novolin R Inj (Injection) U (Unit) = 100 per sliding scale: 201-250 = 3 Units, 251-300 = 6 Units, 301-350 = 9 Units, 351-400 =12 Units and if above 400, staff are to notify the physician."

The facility's procedures entitled, "Guide for

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Storage of Insulin and Insulin Characteristics" with a date of 02/16/07 identifies that Novolin R is a short acting insulin. These procedures also state that it takes about a half hour to one hour for the Novolin R to take effect, that the Novolin R produces a peak in the insulin levels in two and a half to five hours after administration and that the Novolin R lasts about eight to twelve hours. It also states that Novolin R should be administered thirty minutes to one hour before a meal.

In review of R1's Blood Sugar monitoring sheet dated February 2012, this sheet identifies that her blood sugar reading was 203 prior to the lunch meal on 02/11/12. The MAR (Medication Administration Record) for February 2012 does not indicate that nursing staff administered 3 Units of Novolin to R1 on 02/11/12 as based on her blood sugar reading of 203. The front and the back of the MAR for February 2012 was checked and nursing staff did not document on either side of the MAR. No documentation was located to identify that nursing staff administered 3 Units of Novolin R as ordered by the physician when R1's blood sugar readings are between 200 and 250. This monitoring sheet also identifies that a blood sugar reading is to be done prior to the three meals and at bedtime. In reviewing the Blood Sugar monitoring sheet for February 2012, staff failed to document blood sugar readings on: 02/03, 02/12 and 02/13 before the breakfast meal; on 02/04 (Saturday) before the lunch meal and on 02/02 before the dinner meal. There is no further documentation on this sheet, nor included within R1's February Nursing Notes to indicate that nursing staff informed direct care staff to monitor R1 and for what symptoms they are to be monitoring. There is no documentation on this

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W9999	Continued From page 45 Blood Sugar monitoring sheet to show that direct care staff notified nursing staff regarding the lack of a blood sugar reading for 02/02, 02/03, 02/04, 02/12 and/or 02/13/12. R1's Nursing Notes for the month of February 2012 do not identify that nursing staff notified the physician of the lack of blood sugar reading(s) for these dates. The Blood Sugar monitoring sheet and the MAR dated January 2012 identify that nursing staff failed to administer R1 her Novolin injections based on her blood sugar reading as physician ordered on the following dates: 01/03 before dinner, R1's blood sugar reading was 221 and nursing staff did not administer 3 Units as ordered; 01/15 before lunch, R1's blood sugar reading was 308 and nursing staff did not administer 9 Units as ordered; 01/16 before dinner, R1's blood sugar reading was 200 and nursing staff did not administer 3 Units as ordered; 01/21 before lunch, R1's blood sugar reading was 250 and nursing staff did not administer 3 Units as ordered: and before dinner on this date, R1's blood sugar reading was 201 and nursing staff did not administer 3 Units as ordered; 01/22 before lunch, R1's blood sugar reading was 246 and nursing staff did not administer 3 Units as ordered; 01/28 before dinner, R1's blood sugar reading was 220 and nursing staff did not administer 3 Units as ordered; 01/29 before dinner, R1's blood sugar reading was 203 and nursing staff did not administer 3 Units as ordered; and 01/30 before bedtime, R1's blood sugar reading	W9999		

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W9999	Continued From page 46 was 220 and nursing staff did not administer 3 Units as ordered. The Blood Sugar monitoring sheet identifies that a reading is to be done prior to the three meals and at bedtime and in reviewing the sheet for January 2012, blanks were noted on this sheet. Staff failed to document blood sugar readings prior to breakfast on 01/16, 01/20, 01/24 and 01/25, prior to lunch on 01/29, prior to dinner on 01/09 and 01/31 and prior to bedtime on 01/24/12. There is no further documentation on this record, nor included within R1's Nursing Notes for January 2012 to indicate that nursing staff informed direct care staff to monitor R1 and/or informed them of the signs and symptoms they are to be monitoring. This Blood Sugar monitoring sheet does not identify that direct care staff notified nursing staff regarding the lack of a blood sugar reading for 01/09, 01/16, 01/20, 01/24 (twice on this date), 01/25, 01/29 nor on 01/31/12. R1's Nursing Notes for the month of January 2012 do not identify that nursing notified the physician of the lack of blood sugar reading(s) for seven days of the month. E4 (Direct Care staff) was interviewed on 02/01/12 at 4:22 P.M., and stated, "Z1 (LPN - Licensed Practical Nurse) is fairly new and has another job. She can't always get here to give the insulin injections. She can come to the facility after 8:00 P.M. We call her and notify her of R1's blood sugar readings but she can't give her an injection until she get's here which is right around 8:00 P.M." When E4 was asked who would administer R1's insulin injection if her blood sugar was elevated at 12:00 P.M. on the weekends, he stated, "No one. The nurse (Z1) is not able to	W9999		

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come to the facility before 8:00 P.M." E4 was asked who administers R1's insulin on the weekends if she needs it prior to breakfast, and/or at 4:00 P.M. and he stated, "Z1, but she only can come in after 8:00 P.M. and sometimes she is not available to work the weekend." During this interview, E4 confirmed that the facility does not have sufficient nursing staff to administer R1's insulin injections as based on her blood sugar readings which are completed four times daily as ordered by the physician.

Z1 (LPN/Licensed Practical Nurse) was interviewed by phone on 02/06/12 at 6:30 P.M. and stated, "I don't know if they told you, but I quit last Friday (02/03/12). E1 (Administrator) knew I couldn't come in until after 8:00 P.M. I work two jobs and coming in at 8:00 P.M. had not been a problem with E1 prior. She (E1) told me that if R1's blood sugar readings were elevated prior to 8:00 P.M. she would have another nurse (unidentified) come in and administer her insulin. I don't know what happened to them, but I know staff (unnamed) told me at the facility that no one had been coming in over the weekend Friday 01/28, Saturday 01/29 and Sunday 01/30/12."

The Blood Sugar monitoring sheet and the MAR dated January 2012 confirm that no nurse was available to administer R1's Novolin injection as ordered by the physician. R1 did not receive her Novolin injections as based on her blood sugar reading(s) during the weekend of 01/28 (Friday), 01/29 (Saturday) and/or 01/30/12 (Sunday). The Blood Sugar monitoring sheet for 01/28 identifies that before dinner, R1's blood sugar reading was 220 and should have received 3 Units of Novolin. The MAR sheet identifies a blank square for

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01/28/12 for R1's Novolin administration. On 01/29 before dinner, R1's blood sugar reading was 203 and she should have received 3 units of Novolin. The MAR sheet identifies a blank square for 01/29/12 for R1's Novolin administration. On 01/30 before bedtime, R1's blood sugar reading was 220 and she should have received 3 Units of Novolin. The MAR sheet identifies a blank square for 01/30/12 for R1 for Novolin administration.

E1 (Administrator) ws interviewed on 02/07/12 at 1:05 P.M. about the lack of nursing coverage for the weekend of 01/28 - 01/30/12 and stated, "I guess Z1 (LPN) quit Sunday. I guess Friday was her last day. I called E9 (RN) to cover the weekend, but I guess he didn't come in." When E1 was asked who was the facility's RN (Registered Nurse) Consultant and why wasn't this person notified, she stated, "Z3 was our RN Consultant but she gave notice I think around 01/15/12." During this interview E1 confirmed that the facility currently does not have an RN Consultant available for consultation and/or to provide necessary monitoring and assistance to staff for the delivery of nursing services.

Review of the Laboratory results for R1 dated 01/09/12, the following abnormal results were noted:
Potassium 5.5 H (High)
reference range of 3.3 - 5.1
Glucose 131 H
reference range of 70 - 100
BUN 30 H
reference range of 6 - 25
Glomerular Filtration Rate 55
range of 30 - 59 ml (milliliter) indicates a moderate decrease in GFR

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W9999	Continued From page 49 Glycohemoglobin 7.5 H reference range 4 - 6 E1 (Administrator) was interviewed on 02/22/12 at 3:00 P.M. When E1 was asked how you would know that Z2 (R1's physician) had been notified, she stated, "The nurses usually initial that they have reviewed the lab results at the bottom of the page." In reviewing the bottom of the lab pages with E1, no initials were noted at the bottom of the page. During the telephone interview with Z2 (R1's Physician) on 02/07/12 on 10:17 A.M., he stated, "No" when asked if the facility sent him and/or notified him regarding R2's abnormal lab results. The Blood Sugar monitoring sheet and the MAR for the month of December 2011 identifies that nursing staff omitted to give R1 her insulin injections based on her blood sugar reading as physician ordered on the following dates: 12/04 before lunch R1's blood sugar reading was 258 and nursing staff did not administer 6 Units as ordered; 12/06 before dinner R1's blood sugar reading was 204 and before bedtime R1's blood sugar reading was 202 and there is only one entry on the MAR for this date identifying that nursing staff administered only 3 Units of Novolin at an unspecified time; 12/18 before lunch R1's blood sugar reading was 266 and nursing staff did not administer 6 Units as ordered; 12/21 before dinner R1's blood sugar reading was 222 and nursing staff did not administer 3 Units as ordered; 12/24 before lunch R1's blood sugar reading was	W9999		

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W9999	Continued From page 50 307 and nursing staff did not administer 9 Units as ordered; and 12/29 before dinner R1's blood sugar reading was 223 and nursing staff did not administer 3 Units as ordered. Further review of the Blood Sugar monitoring sheet and the MAR for 12/02/11 identifies that no blood sugar reading is documented for this date, however the MAR identifies that R1 received 6 Units of Novolin. The Blood Sugar monitoring sheet and the MAR for the month of November 2011 identify that nursing omitted to give R1 her insulin injections as based on her blood sugar reading as physician ordered on the following dates: 11/01 before dinner R1's blood sugar reading was 380 and nursing staff did not administer 12 Units of Novolin as ordered; 11/05 before lunch R1's blood sugar reading was 208 and nursing staff did not administer 3 Units of Novolin until twelve hours hours later at 8:00 P.M.; 11/06 before breakfast R1's blood sugar reading was 216 and nursing staff did not administer 3 Units of Novolin as ordered; 11/13 before lunch R1's blood sugar reading was 214 and nursing staff did not administer 3 Units of Novolin until twelve hours hours later at 8:00 P.M.; 11/24 before dinner R1's blood sugar reading was 280 and nursing staff did not administer 6 Units of Novolin until three hours hours later at 8:00 P.M.; 11/25 before lunch R1's blood sugar reading was 206 and nursing staff did not administer 3 Units of Novolin until twelve hours hours later at 8:00	W9999		

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	14G277	A. BUILDING _____ B. WING _____	C 03/14/2012

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P.M.; and
11/26 before lunch R1's blood sugar reading was 382 and nursing staff did not administer 12 Units of Novolin until twelve hours hours later at 8:00 P.M..

Review of the Laboratory results for R1 dated 11/09/11, the following abnormal results were noted:

Glucose 139 H (high)
acceptable reference range of 70 - 100;
Glomerular Filtration Rate 49
range of 30 - 59 ml (milliliter) indicates a moderate decrease in GFR
Glycohemoglobin 8.0 H
verified reference range 4 - 6

No Magnesium level was noted on this report as ordered by the physician.

E1 (Administrator) was interviewed on 02/22/12 at 3:00 P.M. and stated, "I think nursing" when asked who notified the physician of R1's lab (laboratory) results of 11/09/11. When asked how you would know that Z2 (R1's physician) had been notified, she stated, "The nurses usually initials that they have reviewed the lab results at the bottom of the page." In reviewing the bottom of the lab pages with E1, Z1's (LPN) initials were noted at the bottom of the page. E1 stated, "I have the fax (facsimile) headers to show that the labs were sent to Z2." At 3:15 P.M., E1 informed the surveyor that she could not find any fax headers showing that nursing sent R1's lab results to Z2. E1 stated, "I think the lab sends Z2 a copy of R1's labs and the nurse is supposed to follow up with the physician about abnormal lab

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results. I'm not sure, but I will call him (Z2) and make sure that he is getting them (R1's lab results)." During the telephone interview with Z2 on 02/07/12 on 10:17 A.M., he stated, "No" when asked if the facility sends him and/or notifies him regarding R2's abnormal lab results.

Further review of the Blood Sugar monitoring sheet for November 2011 identifies that on 11/25/11 before bedtime, R1's blood sugar reading was 419. The MAR for November 2011 identifies that E9 (acting RN/Registered Nurse Consultant) administered 12 Units of Novolin to R1 on this date (11/25/11). The Physician's Orders dated 11/01/11 states that nursing staff are to notify the physician for orders if R1's blood sugar readings are over 400. R1's physician's orders do not state that nursing staff are to administer 12 Units of Novolin if her blood sugar reading is above 400.

The Nursing Notes for 11/25/11 do not reflect that nursing staff notified the physician of R1's elevated blood sugar reading of 419 and/or that the physician was unavailable. There is no documentation that R1 was sent to the emergency room due to her blood sugar reading of 419 as recommended by the American Diabetes Association when the physician is unavailable. No documentation is noted that Z2 (R1's Physician) was notified of R1's blood sugar reading of 419 after this date and as confirmed per telephone interview with Z2 (physician) on 02/07/12 at 10:17 A.M. There is no documentation contained on R1's Blood Sugar monitoring sheet and/or in R1's Nursing Notes identifying that nursing staff instructed direct care staff to monitor R1 for symptoms of thirst or a

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very dry mouth, frequent urination, feeling tired, dry or flushed skin, nausea, vomiting or abdominal pain, shortness of breath, confusion or fruity breath due to her elevated blood sugar level.

Per telephone interview with Z2 (R1's Physician) on 02/07/12 on 10:17 A.M,. he stated, "If she is not getting her insulin injections, she may become hyperglycemic and develop acidosis (a disruption of the body's acid/base balance brought on by a lack of insulin) and or ketoacidosis which could possibly lead to coma and death."

The American Diabetes Association (www.diabetes.org) states, "Ketoacidosis is a serious condition that can lead to diabetic coma (passing out for a long time) or even death. When your cells don't get the glucose they need for energy, your body begins to burn fat for energy, which produces ketones. Ketones are acids that build up in the blood and appear in the urine when your body doesn't have enough insulin. They are a warning sign that your diabetes is out of control..." Further review of this information identifies that "not getting enough insulin" is one of the basic causative factors for developing ketoacidosis.

R1 was interviewed on 02/02/12 at 9:40 A.M. and stated, "I can't give myself an injection. Sometimes I have problems when the nurse doesn't come and give me my insulin. She works and comes here at night." When R1 was asked if she feels any different when she doesn't get her insulin, she stated, "Sometimes I get kind 'a light in my head and I can't think straight. I have to lay

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down. Sometimes I have to go to the restroom a lot. When I need to go, staff have to help me. You know girl, I can't go to the bathroom by myself. I need help. Staff don't always stay with me when I get like that, but I know they have to help everybody else."

Per telephone interview with Z2 (R1's Physician) on 02/07/12 on 10:17 A.M., he stated, "If a nurse is not available to give her her insulin, they can not meet her needs. If she is not getting her insulin injections, she may become hyperglycemic and develop acidosis or ketoacidosis which could lead to possible coma and death. They should be looking for symptoms or complaints of headache, lack of energy, sleepiness, vomiting and diarrhea, fruity breath, and signs of disorientation." When Z2 was asked how long it would take before R1 could become hyperglycemic and/or develop acidosis, he stated, "This could take a while to occur, or it could occur in a few days. She should be getting her medications as ordered. She should not be waiting 'til 8:00 P.M. at night to get her insulin if her blood sugar is elevated at 12:00 P.M. or 4:00 P.M. She should receive her insulin at that time, not four to eight hours later. They (the facility) have not called me and told me anything about R1 not receiving her insulin or their inability to administer her insulin as ordered."

When Z2 was asked if he considered R1 not receiving her insulin or receiving her insulin injection four to eight hours late as a problem, he stated, "It is a very serious problem. This jeopardizes her health. If they are not giving her her insulin injections because a nurse is not available, they are not meeting and can not meet

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W9999	Continued From page 55 her needs. If the nurse is not available, she will require placement in a facility that provides twenty four hour nursing care so that a nurse is always available to give her her insulin injection." (A)	W9999		