**CUMBERLAND MANOR NURSING CENTER**

<table>
<thead>
<tr>
<th>ID</th>
<th>F 000</th>
<th>INITIAL COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>An annual re-certification survey was conducted from 4/26/10 through 4/29/10. An entrance conference was conducted with the Administrator, in the Administration's Office, on 4/29/10 at 7:45 AM. A conference was held in the conference room on 4/29/10 at 11:10 AM, the Administrator, Director of Nursing (DON), Assistant DON, Regional Administrator, Regional Nursing Consultant, and Regional Director of Clinical Services were notified of the findings that are, or are likely to place diabetic residents in a serious and immediate threat to their health. The insulin dependent diabetics have the likelihood of having hypo/hyperglycemic episodes by not having fingerstick glucose testing performed, receiving the wrong insulin or the wrong doses and residents with documented high and low blood sugars did not have the physician notified. The exit conference was conducted in the conference room on 4/29/10 at 5:30 PM, with the Administrator, Director of Nursing, Regional Nurse Consultant, Director of Clinical Services, Regional Clinical Director and Assistant Director of Nursing, Dietary Manager and other staff. The facility was informed of the survey team findings and that this would be an Immediate Jeopardy (IJ).</td>
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</tbody>
</table>

The facility failed to:

1. Ensure that physician's were notified in a timely manner of residents' low and elevated blood sugars.

2. Ensure the physician orders were followed for monitoring/recording blood glucose levels and/or for administering medications.

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*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.*
<table>
<thead>
<tr>
<th>F 000</th>
<th>Continued From page 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.</td>
<td>Ensure correct doses of insulin were administered and ensure orders were obtained for insulin administration.</td>
</tr>
<tr>
<td>4.</td>
<td>Ensure the Consulting Pharmacist monitored, reviewed and identified that medications were administered correctly, that there were no blanks on the Medication Administration Record (MAR) and that medications were ordered by the physician.</td>
</tr>
<tr>
<td>5.</td>
<td>Ensure that an effective and efficient Quality Assurance program identified, monitored and followed up on quality of care issues such as notifying the physician of high and low blood sugars/glucoses, problems with insulin not being administered as ordered or ensuring orders were obtained for insulin administration.</td>
</tr>
<tr>
<td>6.</td>
<td>Ensure that medical records are complete and have accurate documentation.</td>
</tr>
<tr>
<td></td>
<td>The IJ effective date is 4/29/10, and is ongoing until the IJ is removed. The cited tag of F309 and F333 are at a scope and severity of K and are Substandard Quality of Care citations.</td>
</tr>
</tbody>
</table>

F 157 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident, consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or...
**F 157** Continued From page 2

clinal complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(e).

The facility must also promptly notify the resident and, if known, the resident’s legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident’s legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation and interview, it was determined the facility failed to ensure the physician was notified of a low blood sugar of 58 and elevated blood sugars greater than 350 to 400 for 5 of 24 (Residents #18, 20, 23, 26 and 27) sampled residents that the facility had identified and documented as being insulin dependent. The failure to notify the physician of low and elevated blood sugars placed Residents #18, 20, 23, 26 and 27 in Immediate Jeopardy.

(I,J). A conference was held in the conference room on 4/29/10 at 11:10 AM, the Administrator, Director of Nursing (DON), Assistant DON, Regional Administrator, Regional Nursing Consultant, and Regional Director of Clinical...
F 157  Continued From page 3

Services were notified of the findings that placed the diabetic residents in IJ. The IJ effective date is 4/29/10, and is ongoing until the IJ is removed.

The findings included:

1. Medical record review for Resident #26 documented an original admission date of 2/1/09 with diagnoses of Gastroesophageal Reflux Disease, Hypothyroid, Diabetic Gastric Paresis, Dementia with Behaviors, Folic Acid Deficiency, Charcot Joint Disease in Ankles, Depression, and Insulin Dependent Diabetes Mellitus Type 1. Review of a hospital History and Physical dated 8/17/09 for Resident #26 documented "...sent into the emergency room because of an elevated blood sugar... prior to arrival in the emergency room [BS] was greater than 400... was admitted to [named hospital] in 6/09 in diabetic ketoacidosis... had vomited and vomited up all of her breakfast. She [Resident #26] said that she was not nauseated at the present time, and she denied vomiting at the nursing home... Diabetic gastric paresis..."

Review of Resident #26's physician orders dated 12/7/09 and recertification orders dated 1/5/10 documented "...FINGERSTICK BLOOD GLUCOSE BEFORE MEALS AND AT BEDTIME... SLIDING SCALE: WBG [blood glucose results] - [minus] 100 DIVIDED BY 50 = [amount of insulin to be administered] # [number] OF UNITS FOR GLUCOSE > [greater than] 150... NOVOLIN R [Regular]...3U [units] SUBQ [subcutaneous]...TID [three times a day]...IF BLOOD SUGAR IS HIGH TWICE IN A ROW AND MENTAL STATUS HAS CHANGED GET STAT [obtain immediately] BMP [basic metabolic panel]..." There was no documentation of the
F 157  Continued From page 4

Review of Resident #26’s 1/10 Medication Administration Record (MAR) documented the following blood sugar (BS) >350 with no documentation the physician was notified:

- a. 1/1/10 at 7:30 AM - BS results (=) 549.
- b. 1/2/10 at 7:30 AM - BS = 418.
- c. 1/3/10 at 7:30 AM - BS = 418.
- d. 1/5/10 at 7:30 AM - BS = 418.
- e. 1/6/10 at 7:30 AM - BS = 418.
- f. 1/7/10 at 7:30 AM - BS = 418.
- g. 1/7/10 at 9:00 PM - BS = 418.
- h. 1/7/10 at 7:30 AM - BS = 418.
- i. 1/7/10 at 11:30 AM - BS = 418.

A hospital return order dated 1/13/10 for Resident #26 documented "...Nov [Novolin] R 2 units AC [before meals] & [and] HS [bedtime].... Lantus 7 units qhs [every night at bedtime]." There was no order for accuchecks or SSI.

Further review of Resident #26’s 1/10 MAR documented the following BS >350 with no documentation the physician was notified:

- a. 1/14/10 at 5:30 PM - BS = 364.
- b. 1/15/10 at 11:30 AM - BS = 364.
- c. 1/16/10 at 7:30 AM - BS = 364.
- d. 1/17/10 at 5:30 PM - BS = 395.
- e. 1/18/10 at 5:30 PM - BS = 400.
- f. 1/19/10 at 11:30 AM - BS = 357.
- g. 1/19/10 at 5:30 PM - BS = 471.
- h. 1/20/10 at 7:30 AM - BS = 421.
F 157  Continued From page 5

i. 1/21/10 at 11:30 AM - BS = 400.
     j. 1/23/10 at 5:30 PM - BS = HI, no order for unknown range.

Review of the hospital return physician's orders dated 1/29/10 for Resident #26 documented
"...IDDM [Insulin: Dependent Diabetes Mellitus]...
Diabetic gastroparesis... Accu[check] AC & HS c
[with] Sliding Scale... SS [Sliding Scale] = BS -100
[divided by] 50 = units [to administer]... Lantus
10U Sq [subcutaneous] qhs..." There was no
order to clarify which insulin was to be administered for the SSI.

Review of the 1/10 MAR documented a BS result of 400 on 1/29/10 at 9:00 PM. There was no
documentation the physician was notified of the elevated BS.

Review of the 2/10 MAR documented a BS result of 400 on 2/2/10 at 4:30 PM. There was no
documentation the physician was notified of the elevated BS.

Review of the hospital return dated 3/2/10 for
Resident #26 documented a new diagnosis of
Right below the knee Amputation and orders for
"...Accuchecks AC & HS... SSI c Novolin R - BS
-100 [divided by] [blank] # of units..." There was
no documentation of a clarification order for the SSI calculation.

Review of the 3/10 MAR documented "...SSI
Novolin R BS - 100 [divided by] 50 = # units...
Accuchecks AC & HS..." The 3/10 MAR
documented the following BS >350 with no
documentation the physician was notified:
a. 3/2/10 at 7:30 AM - BS = 400.
b. 3/3/10 at 7:30 AM - BS = 400.
Continued From page 6

c. 3/11/10 at 5:30 PM - BS = 399.
d. 3/12/10 at 7:30 AM - BS = 415.
e. 3/13/10 at 7:30 AM - BS = 400.
f. 3/24/10 at 7:30 AM - BS = 400.
g. 3/24/10 at 9:30 PM - BS = 400.
h. 3/25/10 at 5:30 PM - BS = 400.
i. 3/25/10 at 9:30 PM - BS = 400.
j. 3/25/10 at 5:30 PM - BS = 400.
k. 3/25/10 at 9:30 PM - BS = 400.
l. 3/31/10 at 5:30 PM - BS = 400.
m. 3/11/10 at 5:30 PM - BS = 399.

Review of hospital return orders dated 3/23/10 documented "...NOVOLIN R 2 UNITS c MEALS & Q [every] HS... LANTUS INSULIN 12 UNITS Q AM..." A telephone order dated 3/23/10 documented "...RESUME PREVIOUS ACCUCHECKS AC & HS C [with] [NO] S/S [sliding scale insulin]..."

Review of Resident #26's 4/10 recertification orders signed 4/2/10 documented "...FINGERSTICK BLOOD GLUCOSE BEFORE MEALS AND AT BEDTIME... SLIDING SCALE: WBG -100 DIVIDED BY 50 = # OF UNITS FOR GLUCOSE >150... NOVOLIN R 2 units SC [subcutaneous] c meals & QHS... Lantus Insulin 12..."
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<tbody>
<tr>
<td>445262</td>
<td></td>
<td>04/29/2010</td>
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**NAME OF PROVIDER OR SUPPLIER:**
CUMBERLAND MANOR NURSING CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
4343 ASHLAND CITY HWY
NASHVILLE, TN 37218

<table>
<thead>
<tr>
<th>(X4) ID</th>
<th>(X5) ID COMPLETION DATE</th>
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<td>TAG</td>
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<tr>
<th>F 157: Continued From page 7</th>
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<tbody>
<tr>
<td>units sc QAM. &quot; There was no clarification order for whether or not to give SSI as ordered on 3/23/10 or to give SSI as ordered on the recertification orders. There was no order to clarify the type of insulin to be administered for the SSI.</td>
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</table>

Review of the 4/10 MAR documented the following BS >350 with no documentation the physician was notified:

<table>
<thead>
<tr>
<th>Time</th>
<th>BS</th>
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</thead>
<tbody>
<tr>
<td>a. 4/3/10</td>
<td>400</td>
</tr>
<tr>
<td>b. 4/4/10</td>
<td>405</td>
</tr>
<tr>
<td>c. 4/5/10</td>
<td>425</td>
</tr>
<tr>
<td>d. 4/6/10</td>
<td>415</td>
</tr>
<tr>
<td>e. 4/7/10</td>
<td>414</td>
</tr>
<tr>
<td>f. 4/8/10</td>
<td>400</td>
</tr>
<tr>
<td>g. 4/9/10</td>
<td>400</td>
</tr>
<tr>
<td>h. 4/11/10</td>
<td>389</td>
</tr>
<tr>
<td>i. 4/12/10</td>
<td>385</td>
</tr>
</tbody>
</table>

A telephone order written 4/16/10 for Resident #26 documented "...1. No S/S insulin... 2. Lantus insulin 12 units QAM... Continue accuchecks AC & HS [no] S/S... 3. Novolin R 20 units c meals and at HS..."

Review of the 4/10 MAR documented the following BS >350 with no documentation the physician was notified:

<table>
<thead>
<tr>
<th>Time</th>
<th>BS</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. 4/11/10</td>
<td>400</td>
</tr>
<tr>
<td>b. 4/12/10</td>
<td>393</td>
</tr>
<tr>
<td>c. 4/13/10</td>
<td>402</td>
</tr>
<tr>
<td>d. 4/14/10</td>
<td>400</td>
</tr>
<tr>
<td>e. 4/15/10</td>
<td>414</td>
</tr>
<tr>
<td>f. 4/16/10</td>
<td>411</td>
</tr>
<tr>
<td>g. 4/17/10</td>
<td>413</td>
</tr>
<tr>
<td>h. 4/18/10</td>
<td>488</td>
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</table>
F 157  Continued From page 8

Observations in Resident #26's room on 4/28/10 at 9:42 PM, revealed Nurse #11 obtained a BS of 488. Nurse #11 administered 2 units of Novolin R insulin. The physician was not notified of this elevated BS.

During an interview outside Resident #26's room on 4/28/10 at 9:55 PM, Nurse #11 was asked if the facility had a diabetic protocol. Nurse #11 stated, "...We do... doctors sign them individually... some are individualized to the patient." Nurse #11 was asked when he would notify the physician. Nurse #11 stated, "...according to the doctor's orders... if you're asking about [Resident #26], she's a special case... He's [Resident #26's physician] trying to keep her from bottoming out... she drops really fast..."

During a telephone interview in the conference room on 4/28/10 at 2:15 PM, Resident #26's attending physician (MD) was asked about Resident #26. The MD stated that he had taken care of her for about 2 years, that she had seen an endocrinologist, had been tried on an insulin pump, and was a difficult patient. The MD stated, "...she had episodes of hyper and hypoglycemia... approach was to check her blood sugar more frequently... felt hypoglycemia was worse than hyperglycemia with irreversible conditions..." The MD was asked when he would expect the nurses to notify him of elevated or low blood sugars. The MD stated, "...I didn't want them [nurses] to call me every time... I would never get any sleep... not required... If running high 2 to 3 days in a row with a mental status change... would expect to be called... has been to the hospital because she was ketotic... not your usual diabetic patient... nightmare patient... wrote a specific order if it was
F 157 Continued From page 9

high two times to get a STAT BMP and Ketone levels if there is a mental state change... send to hospital... new management is to get them off sliding scale... trying to get her off sliding scale insulin... rather that she ran high than low...

There was no documentation that the physician was notified of the elevated blood sugars, and there was no documentation that the staff obtained orders for the insulin administered for BS readings of 85. The facility glucometers read high if the BS was above 85. Without a numeric value it was not possible to calculate doses for insulin administration.

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Continued From page 10

Clarification... accuchecks TID [three times a day]...” which had been written on the 4/10 recertification orders.

During an interview in the conference room on 4/28/10 at 6:45 AM, the DON was asked what should be done with an order like the range “...230359=4U...” The DON stated, “...[nurses] should have written a clarification order... should be a clarification order...” A clarification telephone order was written on 4/28/10 after the surveyor spoke with the DON, which documented “...Order Clarification...230 - 259 - 4 un [units]...”

Review of Resident #18’s 12/09 MAR documented the following BS >350 with no documentation that the physician was notified:

- a. 12/19/09 at 5:30 PM - BS = 454.
- b. 12/20/09 at 5:30 PM - BS = 379.
- c. 12/31/09 at 5:30 PM - BS = 450.

Review of the 1/10 MAR documented the following BS >350 with no documentation the physician was notified:

- a. 1/5/10 at 5:30 PM - BS = 404.
- b. 1/19/10 at 5:30 PM - BS = 352.
- c. 1/22/10 at 5:30 PM - BS = 367.
- d. 1/22/10 at 9:00 PM - BS = 398.
- e. 1/28/10 at 5:30 PM - BS = 378.
- f. 1/23/10 at 7:30 AM - BS = 405.
- g. 1/29/10 at 5:30 PM - BS = 400.
- h. 1/30/10 at 5:30 PM - BS = 454.
- i. 1/31/10 at 5:30 PM - BS = 394.

Review of Resident #18’s 2/10 MAR documented the following BS >350 with no documentation the physician was notified:

- a. 2/1/10 at 5:30 PM - BS = 376.
- b. 2/3/10 at 5:30 PM - BS = 368.
F 157 Continued From page 11

c. 2/4/10 at 5:30 PM - BS = 410.
d. 2/5/10 at 7:30 AM - BS = 384.
e. 2/5/10 at 5:30 PM - BS = 476.
f. 2/6/10 at 11:30 AM - BS = 384.
g. 2/6/10 at 5:30 PM - BS = 400.
h. 2/7/10 at 9:30 PM - BS = 388.
i. 2/8/10 at 5:30 PM - BS = 371.
j. 2/9/10 at 5:30 PM - BS = 359.
k. 2/10/10 at 5:30 PM - BS = 368.
l. 2/11/10 at 5:30 PM - BS = 362.
m. 2/12/10 at 7:30 AM - BS = 400.
n. 2/13/10 at 5:30 PM - BS = 379.
o. 2/14/10 at 7:30 AM - BS = 387.
p. 2/14/10 at 5:30 PM - BS = 355.
q. 2/15/10 at 5:30 PM - BS = 402.
r. 2/19/10 at 5:30 PM - BS = 400.
s. 2/25/10 at 11:30 AM - BS = 382.

A telephone order dated 3/3/10 for Resident #18 documented "...accucheks TID..."

Review of the March 2010 MAR documented the following BS > 350 with no documentation the physician was notified:
a. 3/1/10 at 5:30 PM - BS = 400.
b. 3/3/10 at 5:30 PM - BS = 400.
c. 3/5/10 at 9:00 PM - BS = 404.
d. 3/7/10 at 9:00 PM - BS = 406.
e. 3/8/10 at 9:00 PM - BS = 403.
f. 3/11/10 at 11:30 AM - BS = 361.
g. 3/11/10 at 9:00 PM - BS = 410.
h. 3/12/10 at 9:00 PM - BS = 409.
i. 3/13/10 at 9:00 PM - BS = 410.
j. 3/15/10 at 9:00 PM - BS = 352.
k. 3/16/10 at 9:00 PM - BS = 353.
l. 3/17/10 at 9:00 PM - BS = 401.
m. 3/19/10 at 9:00 PM - BS = 404.
n. 3/21/10 at 9:00 PM - BS = 410.
o. 3/22/10 at 9:00 PM - BS = 500.
F 157 Continued From page 12

p. 3/22/10 at 7:30 AM - BS = 400.
q. 3/23/10 at 9:00 PM - BS = 430.
r. 3/24/10 at 9:00 PM - BS = 402.
s. 3/25/10 at 9:00 PM - BS = 367.
t. 3/30/10 at 9:00 PM - BS = 401.
u. 3/31/10 at 9:00 PM - BS = 383.

Review of Resident #18's 4/10 MAR documented the following BS >350 with no documentation the physician was notified:
a. 4/6/10 at 7:30 AM - BS = 382.
b. 4/6/10 at 9:00 PM - BS = 407.
c. 4/7/10 at 9:00 PM - BS = 376.
d. 4/9/10 at 9:00 PM - BS = 388.
e. 4/12/10 at 9:00 PM - BS = 405.
f. 4/19/10 at 9:00 PM - BS = 383.
g. 4/22/10 at 9:00 PM - BS = 409.
h. 4/23/10 at 9:00 PM - BS = 400.
i. 4/24/10 at 9:00 PM - BS = 375.
j. 4/26/10 at 9:00 PM - BS = 405.
k. 4/28/10 at 9:00 PM - BS = 333.

Observations in Resident #18's room on 4/29/10 at 8:15 PM, revealed Nurse #11 obtained a fingersstick BS of 383. Nurse #11 did not notify the Medical Doctor (MD) of Resident #18's BS result of 383.

The facility was unable to provide documentation that the physician was notified of Resident #18's blood sugars above 350 as noted above.

3. Medical record review for Resident #20 documented an admission date of 12/12/07 with diagnoses of Type 2 Diabetes Mellitus, Decubitus Ulcer, Dehydration, Dementia, Chronic Obstructive Pulmonary Disease, and Hypertension. Review of the physician's orders dated 3/3/10 and initiated on 12/12/07.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 157</td>
<td></td>
<td></td>
<td>Documented &quot;Novolog Insulin 100U/1ML via/unit see Sliding scale as needed... Fingerstick Blood Glucose before meals and at bedtime Sliding scale: 121-150=2U, 151-200=3U, 201-250=5U, 251-300=6U, 301-350=12U, 351-400=15U and call MD, &lt;70 or &gt;350 Follow Diabetic Protocol...&quot; Review of resident #20's March 2010 MAR documented a blood sugar of 58 on 3/26/10 at 7:30 AM. There was no documentation of interventions put in place for the low BS and there was no documentation the physician was notified of the low BS. During an interview at the nurses' station on 4/28/10 at 10:20 PM, the DON was asked what she expected the staff to do for a BS of 58. The DON stated, &quot;Call the MD.&quot;</td>
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</table>

4. Closed medical record review for resident #23 documented an admission date of 7/5/06 with diagnoses of Hemiplegia status post Cerebral Vascular Accident, Hypertension, Hyperlipidemia, Neurogenic Bladder, Breast Cancer, Diabetes Mellitus, and Diabetic Retinopathy. Review of a hospital return dated 2/11/09 documented "...Blood Glucose AC & HS..." A telephone order dated 2/13/09 documented "...Change Sliding Scale to the following: Regular R Insulin... 121-150 = 1 unit; 151-200 = 2 units; 201-250 = 4 units; 251-300 = 6 units; 301-350 = 8 units; 351-400 = 10 units and notify MD..." A telephone order dated 2/16/09 documented "...Over 400 = 15 units and notify MD..."

Review of the 2/09 MAR documented the following BS >400 without documentation the physician was notified:

a. 2/16/09 at 4:30 PM - BS = 610.
<table>
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<th>(X4) ID</th>
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<th>TAG</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>(X6) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 157</td>
<td>Continued From page 14</td>
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<tr>
<td>b. 2/18/09 at 4:30 PM - BS = 402.</td>
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<tr>
<td>5. Medical record review for Resident #27 documented an admission date of 5/24/04 with diagnoses of Diabetes Mellitus, Hypertension, Paranoia, Coronary Artery Disease, Peripheral Vascular Disease and Congestive Heart Disease. Review of the physician's orders dated 1/5/10 and initiated 6/23/09 for Resident #27 documented: “NOVOLOG INSULIN 100U/1ML VIAL/UNIT SEE SLIDING SCALE AS NEEDED... FINGERSTICK BLOOD GLUCOSE BEFORE MEAL AND AT BEDTIME SLIDING SCALE: 0-120=0U, 121-150=1U, 151-200=2U, 201-250=4U, 251-300=8U, 351-400=10U,...”</td>
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<tr>
<td>Review of the 1/10 MAR documented the following BS &gt;350 with no documentation the physician was notified: a. 1/1/10 at 5:30 PM - BS = HI, no order for unknown range.</td>
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<tr>
<td>b. 1/1/10 at 9:00 PM - BS = 428.</td>
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<tr>
<td>c. 1/2/10 at 5:30 PM - BS = 428.</td>
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<tr>
<td>d. 1/2/10 at 9:00 PM - BS = HI, no order for unknown range.</td>
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<tr>
<td>e. 1/3/10 at 5:30 PM - BS = 489.</td>
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</tr>
<tr>
<td>f. 1/3/10 at 5:30 PM - BS = 488.</td>
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<td>g. 1/4/10 at 5:30 PM - BS = 438.</td>
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<td>k. 1/8/10 at 5:30 PM - BS = HI, no order for unknown range.</td>
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CILA IDENTIFICATION NUMBER

445262

(X2) MULTIPLE CONSTRUCTION

A. BUILD

B. WNG

(X3) DATE SURVEY COMPLETED

04/29/2010

NAME OF PROVIDER OR SUPPLIER

CUMBERLAND MANOR NURSING CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

4343 ASHLAND CITY HWY

NASHVILLE, TN 37218

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES

(Each deficiency must be preceded by full regulatory or LSC identifying information)

ID

PREP

TAG

F 157

Continued from page 15

n. 1/11/10 at 5:30 PM - BS = 535.
o. 1/11/10 at 9:00 PM - BS = HI, no order for unknown range.
p. 1/12/10 at 5:30 PM - BS = 449.
q. 1/12/10 at 9:00 PM - BS = HI, no order for unknown range.
r. 1/13/10 at 5:30 PM - BS = 489.
s. 1/13/10 at 9:00 PM - BS = HI, no order for unknown range.
t. 1/15/10 at 5:30 PM - BS = HI, no order for unknown range.
u. 1/15/10 at 9:00 PM - BS = 448.
v. 1/16/10 at 9:00 PM - BS = 492.
w. 1/18/10 at 7:30 AM - BS = 451.
x. 1/18/10 at 11:30 AM - BS = 415.
y. 1/18/10 at 5:30 PM - BS = HI, no order for unknown range.
z. 1/19/10 at 5:30 PM - BS = 442.

Review of Resident #27's 2/10 MAR documented

If continuation sheet Page 16 of 117
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<td>b.</td>
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<td>c.</td>
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<td>2/9/10 at 5:30 PM - BS = 485.</td>
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Review of the 3/10 MAR documented the
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**CUMBERLAND MANOR NURSING CENTER**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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- **dd.** 3/21/10 at 9:00 PM - BS = 413.
- **ee.** 3/22/10 at 5:30 PM - BS = 428.
- **ff.** 3/24/10 at 9:00 PM - BS = 464.
- **gg.** 3/25/10 9:00 PM - BS = 416.
- **hh.** 3/29/10 at 5:30 PM - BS = 415.
- **ii.** 3/29/10 at 9:00 PM - BS = HI, no order for unknown range.
- **jj.** 3/30/10 at 5:30 PM - BS = HI, no order for unknown range.
- **kk.** 3/30/10 at 9:00 PM - BS = 413.

Observation in Resident #27's room on 4/28/10 at 8:25 PM, revealed Nurse #5 checked Resident #27's BS with results on the accuchek instrument as HI. Nurse #5 gave Resident #27, 5 units of Novolog SUBQ in the right upper arm. The physician was not notified of this elevated BS.

During an interview in the 700 hall on 4/28/10 at 8:50 AM, Nurse #5 was asked at what point would you call the doctor about Resident #27's BS. Nurse #5 stated I use my nursing judgement. Her [Resident #27] BS runs high, I don't need to call him [Doctor].

During an interview in the 700 hall on 4/28/10 at 8:20 PM, Nurse #5 was asked, what do you do for elevated BS. Nurse #5 stated, "I would call the doctor if BS greater 450 or HI on the accuchek from my nursing judgement." Nurse #5 was asked to check the BS result range on the back of the accuchek instrument. Nurse #5 stated, "[The machine reads] 30 to 550."

During an interview outside Room 507 on 4/28/10 at 9:40 AM, Nurse #2 was asked when she would notify the physician of blood sugars.
F 157  Continued From page 20

Nurse #2 stated, "...Our protocol says less than 60... some physicians say less than 70... depends on preference." Nurse #2 was asked when she would notify the physician for high BS. Nurse #2 stated, "...whatever the order say... our protocols are usually greater than 350..." Nurse #2 was asked when she would notify the physician if there was not a specific order. Nurse #2 stated, "...I usually go by the 350... if there's a reason why the others [physicians] want to be notified [at a different BS level]... then I think that's a good number..."

7. The facility was asked for a policy of when to notify physicians related to BS results, the facility provided a handwritten note stating there was no facility protocol/policy for notifying the physician.

During an interview in the conference room on 4/28/10 at 2:25 PM, the Director of Nursing (DON) was asked when she would expect the nurses to notify the physician with regards to blood sugars, since the facility does not have a protocol for the staff to go by. The DON stated, "...our protocol is the standing orders..." and that the nurses would be expected to use their "nursing judgement." The DON was asked that since the standing order only specifies when to call the physician for low blood sugars, when would she expect the nurses to notify the physician for high blood sugars. The DON stated, "...our company doesn't have a protocol..." The DON was then asked as a nurse and the DON, when would she expect the nurses to notify the physicians. The DON stated, "...as a nurse, I would say 350 to 400..." The DON was asked if she would expect the nurses to notify the physician for blood sugars greater than 350. The DON stated, "Yes."
Continued From page 21

8. During a telephone interview in the conference room on 4/29/10 at 9:40 AM, the Medical Director (MD) was asked when he would expect the nurses to notify the physician of high blood sugars. The MD stated, "...would expect the nurses to call if the blood sugar is 350 to 400...blood sugar is too high at 350 to 400...double check if too high...call the lab to get another one [BS] and call the lab for a STAT [obtain immediately] BS...call the physician...physician may send to the ER [emergency room]."

F 221 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS

This REQUIREMENT is not met as evidenced by:
Based on review of the facility's Director of Nursing Training Manual, medical record review, observations, and interview, it was determined the facility failed to ensure restraint assessments and reduction attempts were completed for 1 of 6 (Resident #12) sampled residents with restraints.

The findings included:
Review of the facility's Director of Nursing Training Manual used as the protocol for physical restraints documented "...PROCEDURE STEPS: 1. General Guidelines for use of Restraints A. Restraints include any and all protective devices and techniques to modify behavior which has become a potential hazard to self or others... 1.
**F 221 Continued From page 22**

Mechanical restraints include, but are not limited to:...[rest of text cut off]

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**F 221**

Medical record review for Resident #12 documented an admission date of 11/17/09 with diagnoses of Rhabdomyolysis, Gastritis, Anemia, Hypertension, Dementia, Acute Renal Failure, Stable Cervical 2 Fracture, Ischemic Colitis, Alcohol Abuse, Falls, Chronic Kidney Disease, and Chronic Iron Deficiency Anemia. Review of physician's orders dated 12/14/09 to present for Resident #12 documented an order "When out of bed to Geri-Chair with tray." There was no documentation of a pre-restraint assessment or any attempts to reduce the gerichair restraint since the gerichair was initiated on 12/14/09.

Observations in Resident #12's room during the initial tour on 4/26/10 at 7:30 AM, revealed Resident #12 seated in a gerichair with a tray.

Observations in Resident #12's room on 4/27/10 at 8:15 AM, revealed Resident #12 seated in gerichair with tray.

Observations in Resident #12's room on 4/28/10 at 8:00 AM, revealed Resident #12 seated in gerichair with tray.
F 221: Continued From page 23

During an interview at the Nurses’ Station on 4/27/10 at 11:20 AM, Nurse #2 was asked if any restraint assessments or attempts to reduce the restraint to the least restrictive had been completed for Resident #12. Nurse #2 stated, "I can not find any restraint assessments. I will check with the Director of Nursing or the Assistant Director of Nursing (ADON)." 

During an interview with the ADON at the Nurses’ Station on 4/27/10 at 11:52 AM, the ADON stated, "I do not see any restraint assessments or consents [for Resident #12]."

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident’s needs, and, to the extent practicable, the participation of the resident, the resident’s family or the resident’s legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.
F 280  Continued From page 24  

This REQUIREMENT is not met as evidenced by:  
Based on medical record review and interview, it was determined the facility failed to revise the care plan to reflect the resident's current status for wound care or care for emergency bleeding from the dialysis permacath for 2 of 40 (Residents #13 and 15) sampled residents.  

The findings included:  

F 260  Continued From page 25

PRN. "The plan of care was not revised to reflect dressing change interventions for site of the recent scrotal mass removal and the estimated date to achieve goals on this plan was dated before the plan of care was developed.

During an interview in the 500 hall on 4/27/10 at 8:10 AM, Nurse #4 was asked what type of wound Resident #13 had when he returned from the hospital. Nurse #4 stated, "...he had an open area on his scrotum when he came back from the hospital, they cut a cyst out of his scrotum..."

2. Medical record review for Resident #15 documented an admission date of 10/10/08 and a readmission date of 4/27/10 with diagnoses of Renal Failure, Diabetes Mellitus, Seizure Disorder, Insomnia, Anemia, Arthritis, Hypertension, Renal Disease, Gastrointestinal Bleed, Malnutrition, Slow Fetal Growth and Fetal Malnutrition, and Depression. Review of a physician’s order dated 4/27/10 for Resident #15 documented "...check perma cath [catheter] q shift..." Review of the plan of care dated 3/10/10 documented "...PROBLEMS/STRENGTHS...At risk for bruising/bleeding R/T [related to] ASA [aspirin] usage daily and Heparin use during dialysis. Resident has a port-a-cath shunt to right arm... GOALS... Will identify bruises/bleeding... ESTIMATED DATE... 7/30/2009... INTERVENTIONS... Observe for bruising/bleeding during daily care... Notify MD [Medical Doctor] of significant changes in condition..." Resident #15's plan of care was not revised to reflect interventions for potential bleeding from the dialysis permacath.

During an interview in the 500 hall on 4/28/10 at 10:35 AM, Nurse #9 was asked about the care
F 280  Continued From page 26

plan for bleeding and how staff would know what to do if a dialysis resident began having
complications of hemorrhage from the dialysis site. Nurse #9 stated, "You are gonna know to
hold pressure and call for help..." Nurse #9 was
then asked how a new graduate nurse might
know what emergency steps to take for bleeding
in the care plan did not list emergency
interventions. Nurse #9 looked at the plan of care
to find the needed information. Nurse #9 stated,
"She [graduate nurse] will have had in-service..."

F 282  483.20(k)(3)(i) SERVICES BY QUALIFIED
PERSONS PER CARE PLAN

The services provided or arranged by the facility
must be provided by qualified persons in
accordance with each resident's written plan of
care.

This REQUIREMENT is not met as evidenced
by:

Based on policy review and medical record
review, it was determined the facility failed to
ensure the comprehensive care plan for
monitoring intake and output was followed for 1 of
40 (Residents #4) sampled residents.

The findings included:

- Review of the facility's Intake and Output Record
documented "PROCEDURE Intake and output
must be recorded on the MAR [medication
administration record] each shift on the following
patients... All patients receiving tube feedings."

- Medical record review for Resident #4
documented an admission date of 11/2/06 with
diagnoses of Congestive Heart Failure.
F 282 Continued From page 27

- Hypertension, Dementia, Depression, Benign Prostatic Hypertrophy, Dysphagia, Malnutrition, Anemia, Atrial Fibrillation, Hypokalemia and Depression. Review of the physician's orders for April 2010 (but not dated) had an original order dated 11/29/09 to flush the tube with 60 cubic centimeters of water before and after medication administration. Review of the plan of care with an original date of 11/12/09 and updated on 2/26/10 documented "...Monitor output for amount...
Review of the MAR for January 2010 through March 2010, revealed no documentation of intake and output on the following dates and shifts:
  a. 1/1/10 - 11-7 shift.
  b. 1/8/10 - 3-11 shift.
  c. 1/24/10 - 3-11 shift.
  d. 1/26/10 - 7-3 shift.
  e. 1/27/10 - 11-7 shift.
  f. 1/30/10 - 7-3 shift.
  g. 1/31/10 - 11-7 shift.
Resident #4's care plan was not followed for monitoring intake and output.

F 309

483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

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.

This REQUIREMENT is not met as evidenced by:
Based on review of the "American Diabetes Association" website, policy review, review of facility control drug records, medical record
F 309  Continued From page 28

F 309

review, observation and interview, it was
determined the facility failed to ensure each
resident was provided with necessary care and
services to maintain their highest practical well
being when the facility staff failed to follow
policy/procedures for medication documentation,
follow physician orders, clarify physician orders,
and/or obtain physician orders for 17 of 40 (1, 2,
8, 14, 17, 18, 19, 24, 25, 26, 28, 29, 30, 31, 35,
36, and 37) sampled residents and Random
Resident (RR #1). The facility’s failure to obtain,
clarify, and follow physician orders concerning
blood sugars (BS) placed Residents #2, 8, 14, 17,
18, 19, 24, 25, 26, 28, 29, 30, 31, 35, 36 and 37 in
Immediate Jeopardy (IJ). During a conference
held in the conference room on 4/29/10 at 11:10
AM, the Administrator, Director of Nursing (DON),
Assistant DON, and Regional Director of Clinical
Services were notified of the findings that placed
the diabetic residents in Immediate Jeopardy (IJ).
The IJ effective date is 4/29/10, and is ongoing
until the IJ is removed.

The findings included:

1. Review of the “American Diabetes
Association” website documented “...The A1C
(Hemoglobin (Hgb) A1c - Glycated Hemoglobin -
used to identify the average plasma glucose
concentration over prolonged periods of time) test
measures your average blood glucose control for
the past 2 to 3 months. It is determined by
measuring the percentage of glycated
hemoglobin, or HbA1c, in the blood. Check your
A1C twice a year at a minimum... It does not
replace daily self-testing of blood glucose...
Checking your blood glucose... with a meter tells
you what your blood sugar level is at any one
time... The A1C test gives you a picture of your
Continued from page 29

average blood glucose control for the past 2 to 3 months. The results give you a good idea of how well your diabetes treatment plan is working...
The amount of A1C in your blood reflects blood sugar control for the past 120 days, or the lifespan of a red blood cell... For someone with diabetes and high blood glucose levels, the A1C level is higher than normal. How high the A1C level rises depends on what the average blood glucose level was during the past weeks and months. Levels can range from normal to as high as 25% [percent] if diabetes is badly out of control for a long time..." Review of the Treatment and Care section related to blood glucose control documented "...Hyperglycemia (High blood glucose)... is a major cause of complications with diabetes. Hyperglycemia happens from time to time to all people who have diabetes. Check blood glucose levels to determine when your level is high...The signs and symptoms include the following: High blood glucose... High levels of sugar in the urine... Frequent urination...
Increased thirst... treating high blood glucose early will help you avoid problems associated with hyperglycemia... if your blood glucose is above 240 mg/dL [milligrams per deciliter], check your urine for ketones... Hyperglycemia can be a serious problem if you don't treat it, so it's important to treat as soon as you detect it. If you fail to treat hyperglycemia, a condition called ketoacidosis (diabetic coma) could occur. Ketoacidosis develops when your body doesn't have enough insulin. Without insulin, your body can't use glucose for fuel, so your body breaks down fats to use for energy. When your body breaks down fats, waste products called ketones are produced. Your body cannot tolerate large amounts of ketones and will try to get rid of them. Unfortunately, the body cannot
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...release all the ketones and they build up in your blood, which can lead to ketoacidosis.
Ketoacidosis is life-threatening and needs immediate treatment. Symptoms include:
- Shortness of breath... Breath that smells fruity...
- Nausea and vomiting... Very dry mouth...
- Hypoglycemia (Low blood glucose)... sometimes called an insulin reaction... Symptoms of hypoglycemia include the following: Shakiness...
- Dizziness... Sweating... Hunger... Headache...

Pale skin color, sudden moodiness or behavior changes, such as crying for no apparent reason...
The quickest way to raise your blood glucose and treat hypoglycemia is with some form of sugar...
It's important to treat hypoglycemia quickly because hypoglycemia can get worse and you could pass out. If you pass out, you will need immediate treatment... Hypoglycemia unawareness is when you lose consciousness without ever knowing your blood glucose levels were dropping or that you were showing other symptoms of hypoglycemia...

Continued review of the "American Diabetes Association" website documented the following:
Diabetes increases your risk for many serious health problems such as:
- Eye Complications... higher risk of blindness... 40% more likely to suffer from glaucoma... 60% more likely to develop cataracts.
- Foot Complications... diabetic nerve damage can also lessen your ability to feel pain, heat, and cold... may not feel a foot injury... Foot ulcers...
- Neglecting ulcers can result in infections, which in turn can lead to loss of a limb... People with diabetes are far more likely to have a foot or leg amputated than other people... artery disease reduces blood flow to the feet... reduces sensation... makes it easy to get ulcers and...
Infections that may lead to amputation. Most amputations are preventable with regular care and proper footwear.

c. Peripheral Artery Disease... occurs when blood vessels in the legs are narrowed or blocked by fatty deposits and blood flow to your feet and legs decreases... increased risk for heart attack and stroke... greater risk with high blood pressure, abnormal blood cholesterol levels. Overweight, Not physically active. Over age 50, family history of heart disease, heart attacks, or strokes, and smoking.

d. Ketoacidosis... is a serious condition that can lead to diabetic coma or even death... Usually develops slowly, but when vomiting occurs, this life-threatening condition can develop in a few hours. Early symptoms include thirst, frequent urination, high blood glucose levels, high levels of ketones in urine, constantly feeling tired, dry or flushed skin, nausea/vomiting, abdominal pain, shortness of breath, confusion. "Ketoacidosis is dangerous and serious, and is caused by not enough insulin, not enough food, or an insulin reaction.

e. Kidney Disease... high blood sugar can overwork the kidneys, causing them to stop working properly... when diagnosed later, kidney failure usually results... Once kidneys fail, replacement therapy via dialysis or transplant is necessary.

f. Gastroparesis... type of neuropathy in which food is delayed from leaving the stomach... This nerve damage can be caused by long periods of high blood sugar... can make diabetes worse by making it more difficult to manage blood glucose.

Diabetes may also cause Heart Disease, High Blood Pressure, Neuropathy (Nerve Damage), Hyperosmolar Hyperglycemic Nonketotic
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Syndrome (HHNS), Stroke, and Stress.

During an interview in the conference room on 4/29/10 at 3:30 PM, the Director of Clinical Services stated the corporation is trying to treat insulin dependent diabetics according to the Hgb A1c levels. The Director of Clinical Services stated that they feel it is a better indicator of how the resident is doing, than a one time blood sugar level. The Director of Clinical Services was asked how the Hgb A1c levels could be an accurate reflection of how the resident is doing, if the insulin doses are not being administered correctly. The Director of Clinical Services stated that they [Hgb A1c] would not.

2. Medical record review for Resident #26 documented an original admission date of 2/11/09 with diagnoses of Gastroesophageal Reflux Disease, Hypothyroid, Diabetic Gastric Paresis, Dementia with Behaviors, Folic Acid Deficiency, Charcot Joint Disease in Ankles, Depression, and Insulin Dependent Diabetes Mellitus Type 1. Review of the 1/10 recertification orders dated 1/5/10 documented an order initiated 9/19/09 for "...FINGERSTICK BLOOD GLUCOSE BEFORE MEALS [AC] AND AT BEDTIME [HS]...SLIDING SCALE [SSI]: WBG [blood glucose] = [minus] 100 DIVIDED BY 50 = [equals] # [number] OF UNITS [to give]

["Calculated Dose Insulin"] FOR GLUCOSE > [greater than] 150...NOVOLIN R [regular]...3U [units] SUBQ [subcutaneous] ...TID [three times a day]...LANTUS INSULIN...8U SUBQ AT BEDTIME...IF BLOOD SUGAR IS HIGH TWICE IN A ROW AND MENTAL STATUS HAS CHANGED GET STAT [obtain immediately] BMP [Basic Metabolic Panel]..." There was no documentation of the type of insulin to use for the
Review of Resident #26's January 2010 medication administration record (MAR) documented 7 inaccurate doses of insulin administered, and 4 doses of insulin administered for BS readings of "HI [high]" from 1/1/10 through 1/7/10. Nine units of insulin were administered each time the reading was "HI". There was no numerator to calculate the dosage to give when the reading was "HI", and there was no documentation the physician was notified to obtain an order for the amount of insulin to give when the reading was "HI". The BS with inaccurate doses of insulin ranged from a low of 170 with no [0 units] given to "HI" with 9U given. There was no documentation on the MAR of the type of insulin administered for the SSI.

A hospital return order dated 1/13/10 documented "...Nov [Novolin] R 2 units AC & [and] HS ...Lantus 7 units qhs [every night at bedtime]..." There was no order for accuchecks or SSI.

There were 24 opportunities with inaccurate doses of insulin administered, and 2 doses of insulin administered for BS readings of "HI" from 1/13/10 through 1/25/10. Nine units of insulin were administered each time the reading was "HI", with no numerator to calculate the dosage to give, and no documentation of a physician’s order for how much insulin to give. The BS ranged from 170 with 6U given to "HI" with 9U given.

Review of the hospital return physician’s orders dated 1/29/10 for Resident #26 documented "...IDDM [Insulin Dependent Diabetes Mellitus]... Diabetic gastroparesis... Acu[check] AC & HS c [with] Sliding Scale...SS = BS -100 [divided by] 50
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<td>Continued From page 34</td>
<td>= units [to give]...Lantus 10U Sq [subcutaneous] qhs...&quot; There was no order to clarify which insulin to use for the SSI. The 1/2010 MAR documented 3 inaccurate doses of insulin administered from 1/20/10 through 1/31/10.</td>
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<td>There were 10 opportunities of BS &gt;350, and 6 with readings of &quot;HI&quot;, with no documentation the physician was notified of the elevated BS for the month of January 2010.</td>
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<td>Review of Resident #26's 2/10 MAR documented 3 opportunities with inaccurate doses of insulin administered. The BS ranged from 152 with 0U administered, to 280 with 3U administered. The resident was sent to the hospital on 2/3/10 and did not return until 3/2/10.</td>
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<td>Review of the hospital return dated 3/2/10 for Resident #26 documented a new diagnosis of Right below the knee Amputation and orders for &quot;...Lantus 6u SQ QHS... Accuchecks AC &amp; HS... SSI c Novolin R - BS -100 [divided by] [blank] # of units [to give]...&quot; There was no documentation of a clarification order for the SSI. Review of the 3/10 MAR documented &quot;...SSI Novolin R BS - 100 [divided by] 50 = # units [to give]...Accuchecks AC &amp; HS...&quot;</td>
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<td>Review of the 3/10 MAR documented 23 opportunities with BS &gt;350, and one reading of &quot;HI&quot;, with no documentation the physician was notified. There was no documentation of an order for the 9U administered for the &quot;HI&quot; reading on 3/11/10.</td>
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| | | | Review of the hospital return orders dated 3/23/10 documented "...NOVOLIN R 2 UNITS c MEALS & QHS... LANTUS INSULIN 12 UNITS Q
**F 309** Continued From page 35
AM..." A telephone order dated 3/23/10 documented "...RESUME PREVIOUS ACCUCHECKS AC & HS C [NO] S/S,..."

Review of Resident #28's 4/10 recertification orders signed 4/2/10 documented 
"...FINGERSTICK BLOOD GLUCOSE BEFORE MEALS AND AT BEDTIME... SLIDING SCALE: WBG -100 DIVIDED BY 50 = # OF UNITS FOR GLUCOSE +150...NOVOLIN R 2 units SC c meals & QHS...Lantus Insulin 12 units sc QAM,..."

There was no clarification order for whether to give no SSI as ordered on 3/23/10 or to give SSI as ordered on the recertification orders dated 4/2/10. Review of 4/10 MAR indicated the facility failed to follow the the 4/10 recertification orders signed by the physician on 4/2/10, for calculated dosages of SSI according to accuchecks before meals and at bedtime. There were 25 opportunities with inaccurate calculated doses of insulin administered from 4/1/10 through 4/15/10.

There were 10 opportunities of BS >350, with no documentation the physician was notified. The 10 blood sugars ranged from 369 to 438. The BS with inaccurate dosages of insulin ranged from a low of 164 with 2U given to 425 with 2 units given.

A telephone order written 4/16/10 documented 
"...1. No S/S insulin... 2. Lantus Insulin 12 units QAM... Continue accuchecks AC & HS [no] S/S...3. Novolin R 2 units c meals and at HS..."

There were 8 documented BS >350 from 4/18/10 through 4/28/10 with no documentation the physician was notified. These eight blood sugars ranged from 393 to 488.

Observations in Resident #28's room on 4/28/10 at 9:42 PM, revealed Nurse #11 obtained a BS of 488. The resident was given 2 units of Novolin R...
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During an interview outside Resident #28's room on 4/28/10 at 9:55 PM, Nurse #11 was asked if the facility had a diabetic protocol. Nurse #11 stated, "...We do...doctors sign them individually...some are individualized to the patient..." Nurse #11 was asked when would he notify the physician of B.S. Nurse #11 stated, "...according to the doctor's orders...if you're asking about [Resident #28], she's a special case...He's [physician] trying to keep her from bottoming out...she drops really fast..."

Review of Resident #28's laboratory results documented the following (normal reference range for glucose is 73-107 milligrams per deciliter and the Hbg A1C normal reference range is <7.0 percent):

a. 2/19/09 Glucose = 568 (H! critical high!), Hbg A1C = 8.8 (H [high])
b. 2/23/09 Glucose = 412 (H)
c. 3/10/09 Glucose = 65 (L)
d. 3/12/09 - Hbg A1C = 9.8 (H)
e. 3/17/09 - Hbg A1C = 10.0 (H)
f. 3/19/09 - Glucose = 475 (H)
g. 3/26/09 - Glucose = 493 (H)
h. 5/12/09 - Glucose = 843 (H!), Hbg A1C = 9.0 (H)
i. 5/26/09 - Glucose = 242 (H), Hbg A1C = 9.4 (H)
j. 8/5/09 - Glucose = 237 (H), Hbg A1C = 9.0 (H)
k. 4/2/10 - Hbg A1C = 8.9 (H)

Review of a hospital History and Physical dated 8/17/09 documented "...sent into the emergency room because of an elevated blood sugar...prior to arrival in the emergency room was greater than 400 [blood sugar]... was admitted to [named..."
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hospital] in 06/2009 in diabetic ketoacidosis... had vomited and vomited all of her breakfast. She [Resident #26] said that she was not nauseated at the present time, and she denied vomiting at the nursing home... Diabetic gastric paresis..."

During an interview at the nurses' station with the Director of Nursing (DON) present, on 4/28/10 at 10:12 PM, Nurse #11 was asked how he would calculate the dose of insulin. Nurse #11 stated, "...If it's point something [fraction]... we round up or down... if point 6 [0.6] or point 7 [0.7] round up..." Nurse #11 was asked if the fraction came out to be something point 5 [0.5] would he round up or down, he stated "...If it's 3.5 or point 5 round down... I guess it would be up to the individual nurse..." Nurse #11 was asked if he had had any inservice on how to use the calculated dose insulin, related to fractions of units, and he stated, "No." The DON then stated, "...Yes, you have. Remember? If it's point 5 what do you do?" Nurse #11 stated, "Round down." The DON rolled her eyes upward when Nurse #11 responded. The DON was then asked if that was what the nurses had been instructed in the inservice, and she stated, "...No...round up [for something point 5]." The DON was asked to provide documentation of the inservice related to calculated dose insulin, but no documentation was provided.

During a telephone interview in the conference room on 4/28/10 at 2:15 PM, Resident #26's attending physician (MD) was asked about Resident #26. The MD stated that he had taken care of her for about 2 years, that she had seen an endocrinologist, had been tried on an insulin pump, and was a difficult patient. The MD stated, "...she [Resident #26] had episodes of hyper and
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hypoglycemia... approach was to check her blood sugar more frequently... felt hypoglycemia was worse than hyperglycemia with irreversible conditions..." The MD was asked when he would expect the nurses to notify him of elevated or low blood sugars. The MD stated, "...I didn't want them to call me every time... I would never get any sleep... not required... If running high 2 to 3 days in a row with a mental status change... would expect to be called... has been to the hospital because she was ketotic... not your usual diabetic patient... nightmare patient... wrote a specific order if it was high two times to get a STAT [obtain immediately] BMP [basal metabolic panel] and Ketone levels if there is a mental status change... send to hospital..." The MD was asked how the nurses were supposed to handle blood sugars that read "HI" on the glucometer. The MD stated, "...if blood sugar reads "HI" get BMP and call or send to the hospital..." The MD was asked if he reviewed the MARs when he assessed the residents. The MD stated, "...Yes..." The MD further stated that he was not aware of resident's receiving the wrong doses of insulins. The MD was asked about no longer having the resident on SSI. The MD stated, "...I am trying to get them [insulin dependent diabetics] off SSI... new management is to get them all off of sliding scale insulin... rather that she ran high than low..." The MD was asked if he was comfortable with the staffs' ability to care for his patients. The MD stated, "...they are to follow my orders... that's not for me to say..." The MD was asked specifically about the calculated dose orders. The MD stated, "...moved away from calculated dose... when she first came to the facility she was on it, but then it was changed..." The MD did not answer specifically whether he felt the nurses were able to accurately calculate...
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the doses of insulin. The MD was not aware of the discrepancies of orders on recertifications and staff not obtaining clarification orders when reconciling monthly recertification orders, was not aware of wrong doses of insulin administered to the resident, or of the staff administering insulin without an order for readings of "Hi".

The nurses failed to clarify hospital return and recertification orders for Resident #26 for the type of SSI to be given; failed to ensure recertification orders were complete and accurate for SSI ranges, for frequency of accuchecks; failed to ensure staff consistently applied calculated doses when the results included decimal points, and failed to notify the physician of elevated blood glucose level which resulted in Immediate Jeopardy to this diabetic resident with documented high blood sugars levels and high Hgb A1c levels.

3. Medical record review for Resident #2 documented an admission date of 12/7/09 with diagnoses of Hypertension, Dementia, Gastroesophageal Reflux Disease, Anemia, Neuropathy, History of Cerebral Vascular Accident, and Insulin Dependent Diabetes Mellitus. Review of the January 2010 recertification orders dated 1/5/10 documented "...Accuchecks BID [two times a day]..."

Review of the January 2010 MAR, revealed no fingerstick blood glucose results were documented for:
a. 1/4/10 at 5:30 PM.
b. 1/14/10 at 7:30 AM.
c. 1/16/10 at 7:30 AM.
d. 1/16/10 at 5:30 PM.
e. 1/24/10 at 7:30 AM.
Review of the recertification orders dated 3/1/10 documented "...FINGERSTICK BLOOD GLUCOSE TWICE EVERY DAY..." A hospital return order dated 3/5/10 documented "...ACCUCHECKS AC [before meals] & [and] HS [bedtime] c [with] S/S [sliding scale insulin] NOVOLOGY INSULIN 0 - [to] 120 = [amount of insulin to be administered] 0 [no insulin], 121-150 = 2 U [units], 151-200 = 3 U, 201-250 = 6 U, 251-300 = 9 U, 301-350 = 12 U, 351-400 = 15 U & CALL MD [Medical Doctor]..." There was no accucheck result documented for 3/25/10 at 11:30 AM.

Review of the March 2010 MAR revealed there were 4 doses of Norvasc 10 mg [milligram] ordered daily and not documented as being given; 42 doses of Hydralazine 20 mg ordered three times daily (TID) not documented as being given; 39 doses of Seroquel 50 mg ordered TID not documented as being given; 18 doses of Metoprolol 50 mg ordered twice daily (BID) not documented as being given; 18 doses of Ambien 10 mg ordered every (q) night at bedtime (HS) not documented as being given; 27 doses of Ferrus Sulfate 325 mg TID not documented as being given and 10 doses of Megace 40 mg ordered BID not documented as being given. There was no documentation to explain why the medications were not given as ordered.

Review of the April 2010 recertification orders dated 4/7/10 documented "...Accucheks AC & HS S/S [sliding scales]..." Review of the April 2010 MAR documented 112 opportunities for the blood sugar to be checked. No accucheck results were documented for 4/25/10 at 5:30 PM and 4/25/10 at 9:00 PM.
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Observations in Resident #2's room on 4/28/10 at 8:40 AM, revealed Nurse #11 obtained a fingerstick BS of 327. Nurse #11 administered 7 units of Novolog insulin from a 100 units syringe. The resident should have received 12 units of insulin for a BS of 327 according to the Sliding Scale insulin order.

During an interview at Resident #2's room on 4/28/10 at 8:40 AM, Nurse #11 stated, "...He gets 5 [units], that's 5 [pointed to the 5 on the syringe], so this is 6 [pointed to the line below the 5 unit line]." Nurse #11 actually pointed to the 7 unit line on the syringe, which is what he actually gave Resident #2.

4. Medical record review for Resident #8 documented an admission date of 11/4/09 with diagnoses of Chronic Obstructive Pulmonary Disease, Hypoxia, Renal Failure, Congestive Heart Failure, Hypertension, and Cerebral Vascular Accident and Diabetes Mellitus Type 2. The Physician's order dated 4/2/10 and initiated on 1/25/10 documented "FINGERSTICK BLOOD GLUCOSE THREE TIMES EVERY DAY AND AT BEDTIME."

Review of the February 2010 MAR revealed no fingerstick blood glucose results were documented for 2/9/10 at 9:00 PM.

Review of the March 2010 MAR revealed no fingerstick blood glucose results were documented for 3/27/10 at 12:00 PM.

Review of the April 2010 MAR revealed no fingerstick blood glucose results were documented for 4/24/10 at 6:00 AM.
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5. Medical record review for Resident #14 documented an admission date of 7/24/06 with diagnoses of Hypertension, Hypothyroidism, Chronic Atrial Fibrillation, Asthma, Anemia, Neurogenic Bladder, Degenerative Joint Disease, Dementia, Gastroesophageal Reflux Disease, Osteoarthritis, Percutaneous Endoscopic Gastrostomy (PEG) tube, and Insulin Dependent Diabetes Mellitus. Review of the physician's recertification orders dated 4/6/10 documented an order initiated 4/17/09 for "...FINGERSTICK BLOOD GLUCOSE TWICE A DAY..."

Review of the January 2010 MAR revealed there were no accuchek results documented for:
   a. 1/1/10 at 6:00 AM.
   b. 1/3/10 at 6:00 PM.

Review of the March 2010 MAR revealed there were no accuchek results documented for:
   a. 3/8/10 at 6:00 AM.
   b. 3/20/10 at 6:00 AM.

Review of the April 2010 MAR revealed there were no accuchek results documented for:
   a. 4/11/10 at 6:00 PM.
   b. 4/17/10 at 6:00 AM.
   c. 4/19/10 at 6:00 AM.
   d. 4/25/10 at 6:00 PM.

Review of a physician's order dated 3/25/10 for Resident #14 documented, "...D/C [discontinue] Lotab [Hydrocodone] 5... Darvocet-N 100 q [every] 8 [hours] for pain..." Review of the physician's recertification orders dated 4/8/10 documented "...HYDROCODONE W [with] ACETAMINOPHEN 5-500MG [milligrams]... 1 TAB TWICE DAILY AS NEEDED..." There was
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no documentation on the April recertification orders dated 4/8/10 that the Lortab 5/500mg was discontinued, and the Darvocet-N 100 was not on the April recertification orders. Darvocet-N 100 was written in on the 4/10 MAR and was given three times a day from 4/1/10 through 4/28/10 and give two times on 4/27/10.

6. Medical record review for Resident #17 documented an admission date of 12/18/09 with diagnoses of Diabetes Mellitus and left Partial Foot Amputation. Review of the physician orders initiated on 12/22/09 and recertified on 3/1/10 documented "...CONTINUE STANDING ORDERS... NOVOLOG INSULIN 100U [units] / [per] 1ML [milliliter] VIAL/UNIT FINGERSTICK BLOOD GLUCOSE BEFORE MEALS AND AT BEDTIME W [with] SLIDING SCALE [insulin] 0- [to] 120 = [amount of insulin to be administered] 0U [units]; 121-150 = 2U; 151-200 = 3U; 201-250 = 6U; 251-300 = 9U; 301-350 = 12U; 351-400 = 15U AND CALL MD... If blood sugar is < [less than] 60 mg [milligram] / dl [deciliter], recheck and if still < 60mg/dl hold insulin and immediately begin treatment with one of the following: - One (1) tube of instant glucose - Four (4) glucose tablets (4 grams each) - 1/2 cup (4 oz. [ounces]) of juice... Repeat blood sugar check in 30 minutes and if still < 60mg/dl, notify MD and repeat one of treatments listed above."

Review of Resident #17's January 2010 MAR documented the following blood sugar levels which were within the range to recheck the blood sugar:

a. 1/4/10 at 9 PM BS results (=) 58 with snack given.
b. 1/30/10 at 5:30 PM BS = 50 with snack given. The facility was unable to provide documentation.
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that the blood sugar was rechecked as ordered for these two blood sugars.

Review of the February 2010 MAR revealed there were no accuchek results documented for 2/22/10 at 11:30 AM.

Review of the March 2010 MAR revealed there were no accuchek results documented for:
- a. 3/7/10 at 9:00 PM,
- b. 3/14/10 at 11:30 AM,
- c. 3/25/10 at 5:30 PM.

...accucheks TID..." which had been hand written on the 4/2010 recertification orders.

During an interview in the conference room on 4/28/10 at 9:45 AM, the DON asked what should be done with an order like the range 
...230359=4U..." The DON stated, "...[nurses] should have written a clarification order... should be a clarification order..." A clarification telephone order was written on 4/28/10 after the surveyor spoke with the DON, which documented, "...Order Clarification ...230 - 259 - 4
un[units]..."

Review of the December 2009 MAR documented 120 accucheks obtained without a physician's order.

Review of the January 2010 MAR documented 99 accucheks obtained without a physician's order. On 1/26/10 at 8:00 PM, the Lantus 12 units evening dose of insulin was not documented as being given.

Review of the February 2010 MAR documented 109 accucheks obtained without a physician's order.

Review of the March 2010 MAR documented BS were obtained TID after a telephone order was written 3/3/10. There was no documentation the BS was obtained on 3/6/10 at 11:30 AM.

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documented, "FINGERSTICK BLOOD GLUCOSE
BEFORE MEALS..."

Review of the MAR dated January 2010 revealed
there were no accucheck results documented for
1/27/10 at 5:30 PM.

Review of the physician's recertification orders
dated 4/7/10 and initiated 2/22/10 documented an
order for "FINGERSTICK BLOOD GLUCOSE
730A and 900P."

Review of the March 2010 MAR revealed there
were no accucheck results documented for
3/20/10 at 9:00 PM and 3/25/10 at 7:30 AM.

Review of the April 2010 MAR revealed there
were no accucheck results documented for:
a. 4/16/10 at 9:00 PM.
b. 4/20/10 at 9:00 PM.
c. 4/23/10 at 9:00 PM.

9. Medical record review for Resident #24
documented an admission date of 10/15/08 with
diagnoses of Hypertension, Diabetes Mellitus,
Type II, Cardiovascular Accident, Alcohol Abuse,
Renal Insufficiency, Gastrointestinal Bleed and
Myocardial Infarction. Review of the physician's
orders dated 1/5/10, 2/2/10, and 3/1/10
documented, "FINGERSTICK BLOOD GLUCOSE
BEFORE MEALS AND AT BEDTIME."

Review of the MAR for January 2010 revealed
there were no accucheck results documented for:
a. 1/4/10 at 9:00 PM.
b. 1/8/10 at 5:30 PM and 9:00 PM.
c. 1/26/10 at 9:00 PM.

Review of the MAR for February 2010 revealed
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there were no accuchek results documented for:

a. 2/7/10 at 11:30 AM.
b. 2/27/10 at 9:00 PM.

Review of the MAR for March 2010 revealed there were no accuchek results documented for 3/25/10 at 11:30 AM.

10. Medical record review for Resident #25 documented an admission date of 8/19/2005 with diagnoses of Congestive Heart Failure, Coronary Artery Disease, Diabetes, Weakness, Dementia, Hypertension, Chronic Obstructive Pulmonary Disease, Failure to Thrive, Cardiomyopathy, Pacemaker, Hyponatremia, Renal Insufficiency, Optic Neuropathy, Anemia, Depression. Review of the physician recertification orders dated 1/5/10 and initiated on 10/11/09 documented an order for "FINGERSTICK BLOOD GLUCOSE TWICE EVERY DAY."

Review of the MAR for January 2010 revealed there were no accuchek results documented for 1/2/10 at 5:30 PM and 1/3/10 at 5:30 PM.

11. Medical record review for Resident #28 documented an admission date of 6/2/08 with diagnoses of Renal failure, Arthritis, Dementia, Schizophrenia, Hyperlipidemia, Hypertension, and Diabetes Mellitus. The physician's order signed December 2009 and January 2010 documented an order for: "FINGERSTICK BLOOD GLUCOSE BEFORE MEALS AND AT BEDTIME."

Review of the December 2009 MAR revealed there were no accuchek results documented for 12/15/10 at 9:30 PM.

Review of the January 2010 MAR revealed there...
F 309 Continued From page 48

were no accucheck results documented for
1/23/10 at 11:30 AM.

Review of the February 2010 MAR revealed there
were no accucheck results documented for 11:30
AM.

12. Medical record review for Resident #29
documented an admission date of 4/6/05 with
diagnoses of Cerebral Vascular Accident,
Dysphagia, Anemia, Hypertension,
Hyperlipidemia, Insulin Dependent Diabetes
Mellitus and Renal Insufficiency. The physician's
order signed 1/9/10 documented, "FINGERSTICK
BLOOD GLUCOSE BEFORE MEALS AND AT
BEDTIME..." Review of physician's order signed
2/3/10 documented, "...FINGERSTICK BLOOD
GLUCOSE THREE TIMES EVERY DAY AND AS
NEEDED..."

Review of the January 2010 MAR revealed there
were no accucheck results documented for:
a. 1/5/10 at 11:30 AM.
b. 1/14/10 at 11:30 AM.
c. 1/18/10 at 11:30 AM.
d. 1/20/10 at 9:00 PM.
e. 1/29/10 at 9:00 PM.

Review of the February 2010 MAR revealed there
were no accucheck results documented for 2/5/10
at 11:30 AM.

13. Medical record review for Resident #30
documented an admission date of 5/30/05 with
diagnoses of Renal Insufficiency, Pneumonia,
Hypertension, Alcoholism, Congestive Heart
Failure, Diabetes Mellitus, Dementia, and
Cerebral Vascular Accident. The physician's
order signed for April 2010 with an initial date of
<table>
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<th>F 309</th>
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</thead>
</table>

Review of the March 2010 MAR revealed there were no accucheck results documented for 3/14/10 at 11:30 AM.

Review of the April 2010 MAR revealed there were no accucheck results documented for 4/15/10 at 11:30 AM.

14. Medical Record review for Resient #31 documented an admission date of 10/20/09 with diagnoses of Hypertension, Coronary Artery Disease, Depression, Gastritis, Vascular Dementia, Chest Nodule, Recurring Transient Ischemic Attacks, Left Leg Weakness, Decreased Mental Status, Arterial Stenosis, Diabetes. Review of physician recertification orders dated 1/3/10 and initiated 10/20/09 documented, "FINGERSTICK BLOOD GLUCOSE tid AND AT BEDTIME WITH SLIDING SCALE..." and a physician telephone order dated 2/24/10 documented, "[symbol for decrease] Fingersticks to BID c [with] S/S [sliding scale]..." A physician's recertification order dated 3/3/10 documented, "FINGERSTICK GLUCOSE BID."

Review of the January 2010 MAR revealed there were no accucheck results documented for:
- a. 1/21/10 at 7:30 AM.
- b. 1/23/10 at 8:00 PM.
- c. 1/24/10 at 11:00 AM.
- d. 1/30/10 at 8:00 PM.

Review of the February 2010 MAR revealed there...
F 309: Continued From page 50

were no accucheck results documented for:

a. 2/16/10 at 11:00 AM.
b. 2/21/10 at 11:00 AM.
c. 2/28/10 at 7:30 AM.

Review of March 2010 MAR revealed there were no accucheck results documented for 3/29/10 at 7:30 AM.

15. Medical record review for Resident #35 documented an admission date of 1/22/10 with diagnoses of Osteoarthritis, Bell's Palsy, Persistent Hypoglycemia, End Stage Renal Disease, Hypertension, and Non-insulin Dependent Diabetes Mellitus. Review of physician's orders dated 3/3/10 documented "Accucheck AC & HS 730a, 1130a, 530p, 900p..."

Review of March 2010 MAR revealed there were no accucheck results documented for:

a. 3/8/10 at 9:00 PM.
b. 3/15/10 at 9:00 PM.
c. 3/25/10 at 11:30 AM.

Review of April 2010 MAR revealed there were no accucheck results documented for:

a. 4/2/10 at 11:30 AM.
b. 4/4/10 at 9:30 PM.
c. 4/7/10 at 9:00 AM.
d. 4/18/10 at 5:30 PM.
e. 4/23/10 at 11:30 AM.

16. Medical record review for Resident #36 documented an admission date of 12/17/09 with diagnoses of Diabetes Mellitus, Peripheral Vascular Disease, Hypertension, Chronic Obstructive Pulmonary Disease, Cerebral Vascular Accident with Right Sided Weakness, and Cognitive Deficits. Review of the physician's
F 309. Continued From page 51

Recertification orders dated 1/5/10 documented,

"...FINGERSTICK BLOOD GLUCOSE BEFORE MEALS AND AT BEDTIME..."

Review of January 2010 MAR revealed there were no accucheck results documented for 1/12/10 at 9:00 PM and 1/23/10 at 11:30 AM.

Review of the physician's recertification orders for 2/2/10 documented, "FINGERSTICK BLOOD GLUCOSE BEFORE MEALS AND AT BEDTIME W/SLIDING SCALE..." and a physician's telephone order dated 2/24/10 which documented, "...[decrease] Accucheks to BID 7:30 A & 9:00 P..."

Review of February 2010 MAR revealed there were no accucheck results documented for:

- a. 2/15/10 at 9:00 PM.
- b. 2/16/10 at 9:00 PM.
- c. 2/25/10 at 7:30 AM.
- d. 2/27/10 at 7:30 AM.

Review of physicians recertification order for 3/1/10 documented, "...FINGERSTICK BLOOD GLUCOSE BEFORE MEALS AND AT BEDTIME W/SLIDING SCALE..." with a physician’s telephone order dated 3/8/10 that documented insulin regular (Novolin) ac and hs. Sliding scale = 70 - 150 = 0 units 151-200 = 2 units 201 - 250 = 4 units 251 - 300 = 6 units 301-350 = 8 UNITS 351 - 400 = 10 UNITS."

Review of the March 2010 MAR revealed there were no accucheck results documented for:

- a. 3/14/10 at 11:30 AM.
- b. 3/16/10 at 9:00 AM.
- c. 3/25/10 at 9:00 PM.
<table>
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<tr>
<th>Summary Statement of Deficiencies</th>
<th>Provider’s Plan of Correction</th>
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<tbody>
<tr>
<td>F 309 17. Medical record review for Resident #37 documented an admission date of 1/1/14/08 with diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Hypothyroidism, Schizophrenia, Anemia, Renal Failure, Hypertension, Malnutrition, and Diabetes Mellitus. Review of the 1/10 recertification orders dated 1/5/10 documented &quot;...12/23/09... [handwritten in] PBS [fingerstick blood sugar] [check] TID, 730A, 1130A, &amp; P...NOVOLOG INSULIN... FINGERSTICK BLOOD GLUCOSE BEFORE MEALS AND AT BEDTIME WITH SLIDING SCALE: 150-199=1U; 200-249=2U; 250-299=3U; 300-349=4U; 350-399=5U; &gt;400=5U AND CALL MD...” There was no clarification order to determine how many times to obtain the BS.</td>
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<tr>
<td>F 309 Review of the January 2010 MAR documented BS were obtained AC &amp; HS from 1/1/10 through 1/5/10, and three times a day from 1/7/10 through 1/31/10. Review of the January 2010 MAR revealed there were no accuchek results documented for: a. 1/2/10 at 8:00 PM. b. 1/3/10 at 8:00 PM. c. 1/9/10 at 8:00 PM. Review of the February 2010 MAR documented the BS were obtained three times a day from 2/1/10 through 2/23/10. Review of a telephone order dated 2/24/10 documented &quot;...D/C accuchek QID [four times a day] [change to] BID...” There was no documentation of BS obtained for the following dates: a. 2/14/10 at 8:00 PM. b. 2/28/10 at 8:00 PM. Review of the March 2010 MAR documented no</td>
<td></td>
</tr>
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</table>
BS was obtained on 3/28/10 at 6:00 PM.

Review of the April 2010 recertification orders dated 4/2/10 documented, "...FINGERSTICK BLOOD GLUCOSE TWICE EVERY DAY... NOVOLOG INSULIN... FASTING FINGERSTICK BLOOD GLUCOSE THREE TIMES EVERY DAY WITH SLIDING SCALE..." There was no documentation of a clarification order to clarify how many times the BS was to be obtained.

Review of the April 2010 MAR documented the BS were obtained twice a day. There was no documentation of BS obtained for the following dates:

a. 4/1/10 at 8:00 PM,
b. 4/25/10 at 8:00 PM.

18. Medical record review for Resident #1 documented an admission date of 11/4/09 with diagnoses of Senile Dementia, Parkinson's Disease, Hypertension, Urinary Retention, Depression, Chronic Gastritis and Frequent Falls. The quarterly Minimum Data Set dated 2/15/10 documented Resident #1's cognition as a 1 (modified independence—some difficulty in new situations only). The physician's order dated 4/8/10, documented "CHAIR ALARM WHILE UP IN WC [wheelchair]."

Observations in Resident #1's room on 4/27/10 at 10:30 AM revealed Resident #1 was seated in a wheelchair with a chair alarm attached. Certified Nursing Technician (CNT) #1 assisted Resident #1 from the wheelchair to a bath chair the chair alarm did not sound.

During an interview in Resident #1's room on 4/27/10 at 10:30 AM, CNT #1 was asked why the
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<td>REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
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**F 309** Continued From page 54

- alarm did not sound. CNT #1 checked the alarm and stated "It's [alarm] not on."

During an interview in Resident #1's room on 4/27/10 at 11:15 AM, Resident #1 was asked if she ever turned the alarm off. Resident #1 confirmed that she was not able to turn the alarm off.

During an interview in the 200 hallway on 4/28/10 at 10:47 AM, the surveyor asked CNT #2 about the alarm. CNT #2 stated, "...turned it [alarm] off when I was bathing her and took the linen out and someone got her while I was gone... Should have cut on before I took linen out. That's what I normally do. It slipped my mind. I forgot I cut it off. I know now before I leave the room to cut it on."

**19.** Medical record review for RR #1 documented an admission date of 12/16/09 with diagnoses of Anxiety, Peripheral Vascular Disease, Diabetes Mellitus, and Coronary Atherosclerosis. Review of a physician's order dated 12/16/09 documented "Ativan [Lorazepam] 0.5 mg "PO" [by mouth] 2x [times] day -prn [as needed]." Review of physician's re-admission orders dated 1/16/10 revealed no order for Ativan 0.5 MG tablets.

There were no notations of a physician order for Lorazepam 0.5 MG tablet for RR #1 on the signed and dated Physician Order Forms or Telephone Orders for February 2010, March 2010, and April 2010.

Observations at the 200 hall cart in the nurses station on 4/27/10 at 3:20 PM, revealed a pharmacy control drug record for RR #1 that had a prescription label documenting the dispensing date of 1/7/10 for 30 Lorazepam 0.5 MG tablet
CUMBERLAND MANOR NURSING CENTER

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F 309 Continued From page 55 with directions to give, "1 TAB TWICE DAILY AS NEEDED."

Review of the pharmacy control drug record revealed 8 doses of Lorazepam 0.5 MG tablets that were signed out as administered to RR #1 without a physician's order as follows:

- a. 2/10/10 at 8:00 AM.
- b. 2/18/10 at 9:30 AM.
- c. 2/19/10 at 10:00 AM.
- d. 2/28/10 at 12:00 AM.
- e. 2/28/10 at 11:00 AM.
- f. 3/1/10 at 9:00 AM.
- g. 3/29/10 at 7:30 AM.
- h. 4/14/10 at 11:00 AM.

Review of the medical record revealed the 8 doses of Lorazepam 0.5 MG tablet signed out as administered to RR#1 on the pharmacy control drug record were not recorded as administered by the nurse on the February 2010, March 2010, and April 2010 MARs.

During an interview in the copy room on 4/27/10 at 4:30 PM, Nurse #1 confirmed there was not a physician order for Lorazepam 0.5 MG tablet since 1/18/10 and the 8 doses of Lorazepam 0.5 MG administered to RR #1 on 2/10/10 at 8:00 AM; 2/18/10 at 9:30 AM; 2/19/10 at 10 AM; 2/28/10 at 12 AM; 2/28/10 at 11 AM; 3/1/10 at 9 AM; 3/29/10 at 7:30 AM; and 4/14/10 at 11 AM were administered without a physician order and without documentation on the February 2010, March 2010, and April 2010 MARs.

During an interview in the charting room on 4/28/10 at 9:00 AM, the Assistant Director of Nursing (ADON) confirmed there was not a physician's order for Lorazepam 0.5 MG tablet.
F 309: Continued From page 56

20. Review of the facility's "PROPER ADMINISTRATION AND DOCUMENTATION OF UNIT DOSE MEDICATION" policy documented 

"...4. Be sure to check the labels on the unit dose package against the MAR. If a discrepancy is found, regardless of how small, withhold the medication until you check with the physician or pharmacist... 6. Immediately chart the med [medication] given on the MAR by using TWO (2) initials in the proper block. (a blank space means a medication omission). Medications are not legally administered until documented. 7...Proper MAR Med. Documentation: a. Two (2) initials placed in the appropriate block. b...Chart as soon as meds are given prior to giving med to another resident. Do NOT wait until all meds are given and go to the nurse's station and chart meds. This will cause med charting errors ...e. PRN meds should be documented on the back of the MAR along with an explanation of what was given, why it was given and the results obtained."

21. The facility failed to ensure staff obtained clarification orders for discrepancies in recertification orders when sliding scale insulin ranges were incomplete or inaccurate; failed to ensure orders were obtained for what type of insulin to use for sliding scale; failed to obtain fingerstick blood glucose levels as ordered; and failed to accurately administer insulin as ordered.
F 309 - Continued From page 57
by the physician for the blood glucose levels
obtained placed Resident #2, 8, 14, 17, 18, 19,
24, 25, 26, 28, 29, 30, 31, 35, 36, and 37 at risk
for Immediate Jeopardy. The facility failed to
ensure that physician orders were followed for
safety equipment, and failed to ensure
medications were dispensed and administered as
ordered by the physician.

F 333 - 483.25(m)(2) RESIDENTS FREE OF
SxK: SIGNIFICANT MED ERRORS

The facility must ensure that residents are free of
any significant medication errors.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observations,
and interviews, it was determined the facility failed
to ensure that residents were free of significant
medication errors. Re-certification orders for
sliding scale insulin (SSI) were not accurately
transcribed. The nursing staff failed to administer
the correct amount of insulin according to the
sliding scale, failed to accurately and consistently
administer "calculation based scales" (dosages)
of sliding scale insulin in accordance with
physician orders, and/or failed to obtain orders for
insulin administration. The insulin dependent
diabetics have the high likelihood of having
hypoglycemia and hyperglycemia episodes by
receiving the wrong insulin or the wrong insulin
doses. Administration and Pharmacy
demonstrated no knowledge of the existing
incostancies and errors in the administration of
sliding scale insulin. This resulted in immediate
jeopardy for 15 of 24 (Resident #2, 6, 14, 17, 18,
20, 21, 23, 24, 25, 26, 28, 29, 30, and 36)
sampled residents documented as being insulin
F 333  Continued From page 58

-dependent. A conference was held in the
-conference room on 4/29/10 at 11:10 AM, the
-Administrator, Director of Nursing (DON),
-Assistant DON, Regional Administrator, Regional
-Nursing Consultant, and Regional Director of
-Clinical Services were notified of the findings that
-placed the diabetic residents in Immediate
-Jeopardy (IJ). The IJ effective date is 4/29/10, and
-is ongoing until the IJ is removed.

The findings included:

1. Medical record review for Resident #26
documented an original admission date of
2/11/09 with diagnoses of Gastroesophageal
Reflux Disease, Hypothyroid, Diabetic Gastric
Paralysis, Dementia with Behaviors, Folic Acid
Deficiency, Charcot Joint Disease in Ankles,
Depression, and Insulin Dependent Diabetes
Mellitus Type 1. Review of the 1/10 recertification
orders dated 1/5/10 documented an order
initiated 6/15/09 for "...FINGERSTICK BLOOD
GLUCOSE BEFORE MEALS AND AT
BEDTIME... SLIDING SCALE: WBG [blood
glucose] - [minus] 100 DIVIDED BY 50 = [amount
of insulin to be administered] # [number] OF
UNITS [to give] FOR GLUCOSE > [greater than]
150... NOVOLIN R... 3U [units] SUBQ
[subcutaneous] ...TID [three times a day]...LANTUS INSULIN... 8U SUBQ AT BEDTIME... IF
BLOOD SUGAR IS HIGH TWICE IN A ROW
AND MENTAL STATUS HAS CHANGED GET
STAT [obtain immediately] BMP [Basic Metabolic
Panel]..." There was no documentation of the
type of insulin to use for the sliding scale insulin.

Review of Resident #26's January 2010
medication administration record (MAR)
documented the following significant medication
F 333 Continued From page 59

   errors with no documentation of the type of insulin used:
   a. 1/1/10 at 7:30 AM - blood sugar (BS) results
      (e) 549, Insulin given 8, correct dose 8.88U.
   b. 1/1/10 at 9:00 PM - BS = 174, Insulin given 0,
      correct dose 1.48U.
   c. 1/2/10 at 7:30 AM - BS = high (HI), Insulin
      given 9U, no order for unknown range.
   d. 1/3/10 at 9:00 AM - BS = 280, Insulin given 0,
      correct dose 3.6U.
   e. 1/4/10 at 5:30 PM - BS = 160, Insulin given 0,
      correct dose 1.4U.
   f. 1/5/10 at 7:30 AM - BS = HI, Insulin given 9U,
      no order for unknown range.
   g. 1/5/10 at 5:30 PM - BS = 385, Insulin given 5,
      correct dose 5.72U.
   h. 1/5/10 at 9:00 PM - BS = 186, Insulin given 0,
      correct dose 1.72U.
   i. 1/8/10 at 7:30 AM - BS = HI, Insulin given 9U,
      no order for unknown range.
   j. 1/9/10 at 5:30 AM - BS = 187, Insulin given 1,
      correct dose 1.74U.
   k. 1/7/10 at 7:30 AM - BS = HI, Insulin given 9U,
      no order for unknown range.

   A hospital return order dated 1/13/10 documented
   "...Nov [Novolin] R 2 units AC [before meals] &
   [and] HS [at bedtime] ...Lantus 7 units qhs [every
   night at bedtime]..." There was no order for
   accuchecks or SSI.

   The following are documented significant
   medication errors of SSI given without an order (If
   the previous calculated SSI orders of 1/5/10 had
   been followed, the wrong amount of insulin was
   administered):
   a. 1/15/10 at 11:30 AM - BS = 177, Insulin given
      1U Calculated dose (CD) = 1.54U.
   b. 1/15/10 at 5:30 PM - BS = 354, Insulin given
F 333: Continued From page 60

5U (CD = 5.28U).

c. 1/16/10 at 7:30 AM - BS = HL, Insulin given 9U
cannot calculate an unknown numerator.
d. 1/16/10 at 5:30 PM - BS = 313, Insulin given 5U (CD = 4.28U).
e. 1/17/10 at 5:30 PM - BS = 395, Insulin given 8U (CD = 5.9U).
f. 1/18/10 at 7:30 AM - BS = 154, Insulin given 1U (CD = 1.08U).
g. 1/18/10 at 5:30 PM - BS = 400, Insulin given 6U.
h. 1/18/10 at 9:00 PM - BS = 212, Insulin given 2U (CD = 2.24U).
i. 1/19/10 at 11:30 AM - BS = 357, Insulin given 5U (CD = 5.14U).
j. 1/19/10 at 5:30 PM - BS = 471, Insulin given 7U (CD = 7.42U).
k. 1/20/10 at 7:30 AM - BS = 421, Insulin given 6U (CD = 6.42U).
l. 1/20/10 at 11:30 AM - BS = 240, Insulin given 3U (CD = 2.8U).
m. 1/20/10 at 5:30 PM - BS = 196, Insulin given 1U (CD = 1.92U).
n. 1/20/10 at 9:00 PM - BS = 211, Insulin given 2U (CD = 2.22U).
o. 1/21/10 at 7:30 AM - BS = 267, Insulin given 4U (CD = 3.34U).
p. 1/21/10 at 11:30 AM - BS = 400, Insulin given 6U.
q. 1/21/10 at 5:30 PM - BS = 400, Insulin given 6U.
r. 1/22/10 at 7:30 AM - BS = 327, Insulin given 4U (CD = 4.54U).
s. 1/22/10 at 11:30 AM - BS = 240, Insulin given 2U (CD = 2.8U).
t. 1/22/10 at 5:30 PM - BS = 349, Insulin given 4U (CD = 4.98U).
u. 1/22/10 at 9:00 PM - BS = 290, Insulin given 3U (CD = 3.8U).
F 333: Continued From page 61

- v. 1/23/10 at 5:30 PM - BS = H1, Insulin given 9U (unable to calculate unknown numerator)
- w. 1/23/10 at 9:00 PM - BS = 202, Insulin given 1U (CD = 2.04U).
- x. 1/24/10 at 7:30 AM - BS = 291, Insulin given 1U (CD = 3.82U).
- y. 1/24/10 at 5:30 PM - BS = 176, Insulin given 2U (CD = 1.52U).
- z. 1/25/10 at 7:30 AM - BS = 327, Insulin given 5U (CD = 4.54U).

Review of the hospital return physician’s orders dated 1/29/10 for Resident #26 documented

```
...IDDM [Insulin Dependent Diabetes Mellitus]...
Accu[check] AC & HS c [with] Sliding Scale...SS = BS -100 [divided by] 50 = units [to give]...Lantus 10U Sq [subcutaneous] qhs...”
```

There was no order to clarify which insulin to use for the SSI.

The return 1/10 MAR documented the following significant medication errors:

- a. 1/30/10 at 4:30 PM - BS = 280, Insulin given 3U, correct dose 3.6U.
- b. 1/30/10 at 9:00 PM - BS = 298, Insulin given 3U, correct dose 3.95U.
- c. 1/31/10 at 9:00 PM - BS = 296, Insulin given 3U, correct dose 3.92U.

Review of the 2/10 MAR documented the following significant medication errors:

- a. 2/1/10 at 11:30 AM - BS 152, Insulin given 0U, correct dose 1.04U.
- b. 2/1/10 at 4:30 PM - BS 159, Insulin given 0U, correct dose 1.18U.
- c. 2/2/10 at 9:00 PM - BS 280, Insulin given 3U, correct dose 3.6U.

Review of the hospital return dated 3/2/10 for Resident #26 documented a new diagnosis of Right below the knee Amputations and orders for
CUMBERLAND MANOR NURSING CENTER

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F 333: Continued From page 62

"...Lantus 8u SQ QHS... Accucheks AC & HS...
SSI c Novolin R - BS -100 [divided by] [blank] # of units [to give]...
There was no documentation of a clarification order for the SSI. Review of the 3/10 MAR documented "...SSI Novolin R BS -100 [divided by] 50 = # units [to give]... Accucheks AC & HS."

The 3/10 MAR documented a significant medication error:
a. 3/11/10 at 11:30 AM - BS = H1, Insulin given 9U, no order for unknown range.

Review of the hospital return orders dated 3/23/10 for Resident #29 documented
"...NOVOLIN R 2 UNITS c MEALS & QHS... LANTUS INSULIN 12 UNITS Q AM..." A telephone order dated 3/23/10 documented
"...RESUME PREVIOUS ACCUCHECKS AC & HS C [NO] S/S [sliding scale insulin]..."

Review of the 4/10 recertification orders signed 4/2/10 documented "...FINGERSTICK BLOOD GLUCOSE BEFORE MEALS AND AT BEDTIME... SLIDING SCALE: WBG -100 DIVIDED BY 50 = # OF UNITS FOR GLUCOSE >150... NOVOLIN R 2 units SC c meals & QHS...Lantus Insulin 12 units SC QAM..." There was no clarification order for whether to give no SSI as ordered on 3/23/10 or to give SSI as ordered on the recertification orders.

Review of the 4/10 MAR documented the following significant medication errors:
a. 4/1/10 at 7:30 AM - BS = 245, Insulin given 2U, correct dose 2.9U.
b. 4/1/10 at 5:30 PM - BS = 237, Insulin given 2U, correct dose 2.74U.
c. 4/2/10 at 7:30 AM - BS = 246, Insulin given 2U,
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correct dose 2.92U.
d. 4/2/10 at 9:00 PM - BS = 313, Insulin given 2U, correct dose 4.28U.
e. 4/3/10 at 7:30 AM - BS = 164, Insulin given 2U, correct dose 1.28U.
f. 4/3/10 at 9:00 PM - BS = 400, Insulin given 2U, correct dose 6U.
g. 4/4/10 at 7:30 AM - BS = 329, Insulin given 2U, correct dose 4.58U.
h. 4/4/10 at 11:30 AM - BS = 169, Insulin given 2U, correct dose 1.38U.
i. 4/4/10 at 5:30 PM - BS = 405, Insulin given 2U, correct dose 6.1U.
j. 4/4/10 at 9:00 PM - BS = 300, Insulin given 2U, correct dose 4U.
k. 4/5/10 at 7:30 AM - BS = 425, Insulin given 2U, correct dose 6.5U.
l. 4/5/10 at 11:30 AM - BS = 325, Insulin given 2U, correct dose 4.5U.
m. 4/6/10 at 5:30 PM - BS = 415, Insulin given 2U, correct dose 6.3U.
n. 4/6/10 at 9:00 PM - BS = 270, Insulin given 2U, correct dose 3.4U.
o. 4/7/10 at 9:00 PM - BS = 414, Insulin given 2U, correct dose 6.28U.
p. 4/8/10 at 9:00 PM - BS = 171, Insulin given 2U, correct dose 1.42U.
q. 4/9/10 at 9:00 PM - BS = 400, Insulin given 2U, correct dose 6U.
r. 4/10/10 at 9:00 PM - BS = 168, Insulin given 2U, correct dose 1.36U.
s. 4/13/10 at 5:30 PM - BS = 400, Insulin given 2U, correct dose 6U.
t. 4/13/10 at 9:00 PM - BS = 400, Insulin given 2U, correct dose 6U.
u. 4/14/10 at 7:30 AM - BS = 389, Insulin given 2U, correct dose 5.78U.
v. 4/14/10 at 5:30 PM - BS = 375, Insulin given 2U, correct dose 5.5U.
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- 4/14/10 at 9:00 PM - BS = 275, Insulin given 2U, correct dose 3.5U.
- 4/15/10 at 7:30 AM - BS = 342, Insulin given 2U, correct dose 4.84U.
- 4/15/10 at 9:00 PM - BS = 265, Insulin given 2U, correct dose 3.3U.

Review of 4/10 MAR indicated the facility failed to follow the MAR recertification orders signed by the physician on 4/2/10, for calculated dosages of SSI according to accuchek before meals and at bedtime.


Observations in Resident #26's room on 4/28/10 at 9:42 PM, Nurse #11 obtained a BS of 488. The resident was given 2 units of Novoln R insulin without an order.

Review of Resident #26's Hemoglobin (Hgb) A1c - Glycated Hemoglobin laboratory results documented the following:
- 2/19/09 - Glucose = 568 (HI [critical high]), Hgb A1C = 8.5 (HI [high])
- 3/12/09 - Hgb A1C = 9.8 (H)
- 3/17/09 - Hgb A1C = 10.0 (H)
- 5/12/09 - Glucose = 843 (HI), Hgb A1C = 9.0 (H)
- 5/26/09 - Glucose = 242 (H), Hgb A1C = 9.4 (H)
- 8/5/09 - Glucose = 237 (H), Hgb A1C = 9.0 (H)
- 4/2/10 - Hgb A1C = 8.9 (H)

During an interview outside Resident #26's room...
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on 4/28/10 at 9:55 PM, Nurse #11 was asked if the facility had a diabetic protocol. Nurse #11 stated, "...We do... doctors sign them individually... some are individualized to the patient..." Nurse #11 was asked when would notify the physician. Nurse #11 stated, "...according to the doctor's orders... if you're asking about [Resident #26], she's a special case... He's [physician] trying to keep her from bottoming out... she drops really fast..."

During an interview at the nurses' station with the DON present, on 4/28/10 at 10:12 PM, Nurse #11 was asked how he would calculate the dose of insulin. Nurse #11 stated, "...If it's point something [fraction]... we round up or down... if point 6 [0.6] or point 7 [0.7] round up..." Nurse #11 was then asked if the fraction came out to be something point 5 (0.5) would he round up or down. Nurse #11 stated, "...if it's 3.5 or point 5 round down... I guess it would be up to the individual nurse..." Nurse #11 was asked if he had any inservice on how to use the calculated dose insulin, related to fractions of units. Nurse #11 stated, "No." The DON then stated, "...Yes, you have. Remember? If it's point 5 what do you do?" Nurse #11 stated, "Round down." The DON rolled her eyes upward when Nurse #11 responded. The DON was then asked if that was what the nurses had been instructed in the inservice. The DON stated, "...No...round up [for something point 5]." The DON was asked to provide documentation of the inservice related to calculated dose insulin. The DON provided no documentation of the inservice.

During a telephone interview in the conference room on 4/28/10 at 2:15 PM, Resident #26's attending physician (MD) was asked about
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Resident #26. The MD stated that he had taken care of her (Resident #26) for about 2 years, that she had seen an endocrinologist, had been tried on an insulin pump, and was a difficult patient. The MD stated, "...she had episodes of hyper and hypoglycemia... approach was to check her blood sugar more frequently... felt hypoglycemia was worse than hyperglycemia with irreversible conditions..." The MD was asked when he would expect the nurses to notify him of elevated or low blood sugars. The MD stated, "...I didn't want them to call me every time... I would never get any sleep... not required... If running high 2 to 3 days in a row with a mental status change... would expect to be called... has been to the hospital because she was ketotic... not your usual diabetic patient... nightmare patient... wrote a specific order if it was high two times to get a STAT BMP and Ketone levels if there is a mental status change... send to hospital..." The MD was asked how the nurses were supposed to handle blood sugars that read "HI" on the glucometer. The MD stated, "...if blood sugar reads "HI" get BMP and call or send to the hospital..." The MD was asked if he reviewed the MARs when he assessed the residents. The MD stated, "...Yes..." The MD further stated that he was not aware of resident's receiving the wrong doses of insulin. The MD was asked about no longer having the resident on SSI. The MD stated, "...I am trying to get them [insulin dependent diabetics] off SS... new management is to get them all off of sliding scale insulin... rather that she ran high than low..." The MD was asked if he was comfortable with the staff's ability to care for his patients. The MD stated, "...they are to follow my orders... that's not for me to say..." The MD was asked specifically about the calculated dose orders. The MD stated, "...moved away from
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1. Calculated dose... when she first came to the facility she was on it, but then it was changed..."

The MD did not answer specifically whether he felt the nurses were able to accurately calculate the doses of insulin. The MD was not aware of the discrepancies of orders on the recertifications and staff not obtaining clarification orders when reconciling monthly recertification orders, was not aware of wrong doses of insulin administered to the resident, or of the staff administering insulin without an order for readings of "HI".

The facility failed to clarify hospital return and recertification orders for what type SSI was to be given; failed to ensure recertification orders were complete and accurate for SSI ranges, for frequency of accucheks, and for the type of insulin ordered for SSI; and failed to ensure staff consistently applied calculated doses when the results included decimal points which resulted in significant medication errors which place Resident #26 in immediate jeopardy. Resident #26 had documented high blood sugar levels and high Hemoglobin (Hgb) A1c levels.

2. Medical record review for Resident #2 documented an admission date of 12/7/09 with diagnoses of Hypertension, Dementia, Gastroesophageal Reflux Disease, Anemia, Neuropathy, history of Cerebral Vascular Accident, and Insulin Dependent Diabetes Mellitus. A hospital return order dated 3/5/10 documented "...ACCUCHECKS AC & HS c S/S (sliding scale insulin) NOVOLOG INSULIN 0 - [to] 120 = [amount of insulin to be administered] 0,

121-150 = 2U [units], 151-200= 3U, 201-250= 6U,
251-300 = 9U, 301-350 = 12U, 351-400 = 15U &
CALL MD..."
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Review of Resident #2's 3/10 MAR documented the following significant medication errors:

a. 3/6/10 at 7:30 AM - BS = 127, Novolog insulin given 0, correct dose 2U.

b. 3/6/10 at 11:30 AM - BS = 131, Novolog insulin given 0, correct dose 2U.

c. 3/28/10 at 7:30 AM - BS = 129, Novolog insulin given 0, correct dose 2U.

d. 3/31/10 at 7:30 AM - BS = 212, Novolog insulin given 0, correct dose 6U.

Review of Resident #2's 4/10 MAR documented the following significant medication error:

a. 4/9/10 at 7:30 AM - BS = 127, Novolog insulin given 0, correct dose 2U.

Observations in Resident #2's room on 4/28/10 at 8:40 PM, revealed Nurse #11 obtained a fingerstick BS from Resident #2 with a result of 327. Nurse #11 administered 7 units of Novolog insulin (wrong dose). Resident #2 should have received 12 units for a BS of 327.

During an interview in Resident #2's room on 4/28/10 at 8:40 AM, Nurse #11 stated, "...He gets 6 [units], that's 6 [pointed to the 5 unit line on the syringe], so this is 6..." Nurse #11 actually pointed to the 7 unit line on the syringe, which is what he actually gave Resident #2.

3. Medical record review for Resident #3 documented an admission date of 10/28/08 with diagnoses of Chronic Obstructive Pulmonary Disease, Diabetes Mellitus Type 2, Hypoxia, Renal Failure, Congestive Heart Failure, Cerebral Vascular Accident, and Hypertension. A physician's order dated 4/2/10 documented an order initiated on 6/11/09 for "SLIDING SCALE: 230-289=3U, 290-349=5U, 350-409=7U, >"
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[greater than] 410=8U..." and an order initiated
1/25/10 for "...FINGERSTICK BLOOD GLUCOSE
THREE TIMES EVERY DAY AND AT
BEDTIME..." There was no documentation of
which type of insulin to use for the SSI, and there
was no documentation that a clarification order
was obtained to determine which insulin to use for
SSI.

Review of Resident #8's 2/10 MAR documented
the following significant medication error:
- 2/8/10 at 9:00 PM - BS = 249, Insulin given 0,
correct dose 3U.

4. Medical record review for Resident #14
documented an admission on 7/24/06 with
diagnoses of Hypertension, Hypothyroidism,
Chronic Atrial Fibrillation, Asthma, Anemia,
Neurogenic Bladder, Degenerative Joint Disease,
Dementia, Gastroesophageal Reflux Disease,
Osteoarthritis, Percutaneous Endoscopic
Gastrostomy (PEG) tube, and Insulin Dependent
Diabetes Mellitus. Review of the physician's
recertification orders dated 4/8/10 documented an
order initiated 4/17/09 for "...FINGERSTICK
BLOOD GLUCOSE TWICE A DAY..." and an
order initiated 4/29/09 for "...SLIDING SCALE:
121-150=1U, 151-200=2U, 201-250=4U,
251-300=6U, 301-350=8U, 351-400=10U, < [less
than] 70 OR >350 CALL MD..." There was no
documentation of which type of insulin to use for
the SSI, and there was no documentation that a
clarification order was obtained to determine
which insulin to use for SSI until a telephone
order dated 3/1/10 which documented, "...Order
Clarification: S/S c Novolog insulin..."

Review of Resident #14's 1/10 MAR documented
the following significant medication errors:
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- a. 1/1/10 at 6:00 PM - BS = 127, Insulin given 0,
correct dose 1U.
- b. 1/2/10 at 6:00 PM - BS = 130, Insulin given 0,
correct dose 1U.
- c. 1/5/10 at 6:00 PM - BS = 127, Insulin given 0,
correct dose 1U.
- d. 1/6/10 at 6:00 AM - BS = 123, Insulin given 0,
correct dose 1U.
- e. 1/11/10 at 6:00 PM - BS = 126, Insulin given 0,
correct dose 1U.
- f. 1/15/10 at 6:00 PM - BS = 121, Insulin given 0,
correct dose 1U.
- g. 1/16/10 at 6:00 AM - BS = 153, Insulin given 0,
correct dose 2U.
- h. 1/18/10 at 6:00 PM - BS = 139, Insulin given 0,
correct dose 1U.
- i. 1/19/10 at 6:00 PM - BS = 121, Insulin given 0,
correct dose 1U.
- j. 1/20/10 at 6:00 AM - BS = 146, Insulin given 0,
correct dose 1U.
- k. 1/20/10 at 6:00 PM - BS = 130, Insulin given 0,
correct dose 1U.
- l. 1/24/10 at 6:00 AM - BS = 128, Insulin given 0,
correct dose 1U.
- m. 1/25/10 at 6:00 AM - BS = 132, Insulin given 0,
correct dose 1U.
- n. 1/28/10 at 6:00 PM - BS = 123, Insulin given 0,
correct dose 1U.

There was no documentation on the MAR of
which type of insulin was used for the SSI doses
given.

Review of Resident #14's 2/10 MAR documented
the following significant medication errors:
- a. 2/3/10 at 6:00 AM - BS = 153, Insulin given 0,
correct dose 2U.
- b. 2/10/10 at 6:00 PM - BS = 124, Insulin given 0,
correct dose 1U.
- c. 2/11/10 at 6:00 PM - BS = 130, Insulin given 0,
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correct dose 1U.

d. 2/14/10 at 6:00 PM - BS = 122, Insulin given 0, correct dose 1U.
e. 2/22/10 at 6:00 AM - BS = 124, Insulin given 0, correct dose 1U.
f. 2/26/10 at 6:00 AM - BS = 231, Insulin given 0, correct dose 4U.

There was no documentation on the MAR of which type of insulin was used for the SSI doses given.

Review of Resident #14’s 3/10 MAR documented the following significant medication errors:

a. 3/3/10 at 6:00 PM - BS = 143, Novolog insulin given 0, correct dose 1U.
b. 3/26/10 at 6:00 AM - BS = 145, Novolog insulin given 0, correct dose 1U.
c. 3/26/10 at 6:00 AM - BS = 125, Novolog insulin given 0, correct dose 1U.

d. Review of Resident #14’s 4/10 MAR documented the following significant medications error:

a. 4/8/10 at 6:00 AM - BS = 122, Novolog insulin given 0, correct dose 1U.

5. Medical record review for Resident #17 documented an admission date of 12/18/09 with diagnoses of Diabetes Mellitus and a Left Partial Foot Amputation. The standing orders dated 12/23/09 documented “…If blood sugar is <60mg/dl [milligrams per deciliter], recheck and if still <60mg/dl hold insulin (if ordered) and immediately begin treatment with one of the following: One (1) tube of instant glucose... Four (4) glucose tablets (4 grams each) ...½ cup (4 oz. [ounces]) of juice... Repeat blood sugar check in 30 minutes and if still, <60mg/dl notify MD and repeat one of the treatments listed above…”

- Review of the physician's recertification orders
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dated 3/1/10 and initiated on 12/29/09 documented "...Accuchek times 730 A, 1130A, 530P, 900P... NOVOLOG INSULIN... FINGERSTICK BLOOD GLUCOSE BEFORE MEALS AND AT BEDTIME W/ SLIDING SCALE.--0-120 =0U; 121-150 = 2U; 151-200 = 3U; 201-250 = 6U; 251-300 = 9U; 301-350 = 12U; 351-400 = 15U AND CALL MD...."

Review of Resident #17's 1/10 MAR documented the following significant medication error:

a. 1/25/10 at 5:30 PM - BS = 381, Novolog Insulin given 12U, correct dose 15U.

Review of the 3/10 MAR documented the following significant medication errors:

a. 3/9/10 at 5:30 PM - BS = 337, Novolog Insulin given 15U, correct dose 12U.

b. 3/10/10 at 11:30 AM - BS = 155, Novolog Insulin given 2U, correct dose 3U.


Review of Resident #18's 12/09 MAR documented the following significant medication errors (the MAR had been changed manually to
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230 - 259 = 4U, however the clarification order was not written until 4/28/10:

a. 12/6/09 at 7:30 AM - BS = 329, Novolog insulin given 4U, correct dose 8U.
b. 12/10/09 at 9:00 PM - BS = 169, Novolog insulin given 0, correct dose 1U.
c. 12/11/09 at 9:00 PM - Lantus 10 U not documented as given.
d. 12/15/09 at 7:30 AM - BS = 141, Novolog insulin given 0, correct dose 1U.
e. 12/25/09 at 11:30 AM - BS = 154, Novolog insulin given 0, correct dose 1U.

A telephone order dated 12/16/09 documented "...[increase] Lantus insulin to 12 units SQ QHS...". Review of the 1/10 MAR documented the following significant medication errors (the MAR had been changed manually to 230 - 259 = 4U, however the clarification order was not written until 4/28/10):

a. 1/14/10 at 11:30 AM - BS = 267, Novolog insulin given 0, correct dose 5U.
b. 1/26/10 at 8:00 PM, Lantus 12 U not documented as given.
c. 1/29/10 at 7:30 AM - BS = 403, Novolog insulin given 10, correct dose 9U.

Review of Resident #18's 2/10 MAR documented the following significant medication errors (the MAR had been changed manually to 230 - 259 = 4U, however the clarification order was not written until 4/28/10):

a. 2/2/10 at 5:30 AM - BS = 170, Novolog insulin given 0, correct dose 2U.
b. 2/4/10 at 8:00 PM, Lantus 12 U not documented as given.
c. 2/6/10 at 11:30 AM - BS = 384, Novolog insulin given 10, correct dose 9U.
d. 2/22/10 at 11:30 AM - BS = 248, Novolog
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   insulin given 2U, correct dose 4U.
   e. 2/24/10 at 11:30 AM - BS = 132, Novolog
      insulin given 1U, correct dose 0U.
   f. 2/25/10 at 11:30 AM - BS = 362, Novolog
      insulin given 0, correct dose 8U.
   g. 2/26/10 at 8:00 PM, Lantus 12U not
      documented as given.

   There was no documentation of an order for
   fingerstick BS until a telephone order dated
   3/3/10 for "...Order Clarification... accuchecks TID
   [three times a day]." which was hand-written on
   the 4/10 recertification orders.

   Review of Resident #18's 3/10 MAR documented
   the following significant medication errors (the
   MAR had not been changed for the 230359 = 4U,
   however the clarification order was not written
   until 4/28/10):
   a. 3/1/10 at 7:30 AM - BS = 331, Novolog insulin
      given 4U, correct dose 8U.
   b. 3/5/10 at 7:30 AM - BS = 339, Novolog insulin
      given 4U, correct dose 8U.
   c. 3/9/10 at 8:00 PM - BS = 339, Novolog insulin
      given 4U, correct dose 8U.
   d. 3/15/10 at 9:00 PM - BS = 353, Novolog insulin
      given 4U, correct dose 8U.
   e. 3/17/10 at 9:00 PM - BS = 333, Novolog insulin
      given 4U, correct dose 8U.
   f. 3/18/10 at 9:00 PM - BS = 273, Novolog insulin
      given 4U, correct dose 5U.

   Review of the physician's recertification order
   dated 4/2/10 documented an order initiated 6/4/09
   for "...NOVOLOG INSULIN...SEE SLIDING
   SCALE AS NEEDED... SLIDING SCALE: CALL
   MD IMMEDIATELY FOR BLOOD SUGAR <60;
   140-169=[EQUALS]1U, 170-199=2U,
   200-229=3U, 230359=4U, 260-289=5U,
Review of Resident #18's 4/10 MAR documented the following significant medication errors (the MAR had been changed manually to 230 - 259 = 4U, however the clarification order was not written until 4/28/10):

a. 4/1/10 at 9:00 PM - BS = 277, Novolog insulin given 0, correct dose 5U.
b. 4/2/10 at 7:30 AM - BS = 324, Novolog insulin given 4, correct dose 8U.

During an interview in the conference room on 4/28/10 at 9:45 AM, the DON was asked what should be done with an order like the range "...230359=4U..." The DON stated, "...[nurses] should have written a clarification order... should be a clarification order..." A clarification telephone order was written on 4/28/10 after the surveyor spoke with the DON, which documented "...Order Clarification:...230 - 259 - 4 U [equals 4 units]..."

Nurses continued to administer incorrect doses of SSI and failed to contact the physician for a clarification order until after the surveyor brought it to the DON's attention on 4/28/10.

7. Medical record review for Resident #20 documented an admission date of 12/12/07 with diagnoses of Type 2 Diabetes Mellitus, Decubitus Ulcer, Dehydration, Dementia Chronic Obstructive Pulmonary Disease and Hypertension. Review of the physician's orders dated 4/8/10 documented, "...Novolog Insulin... Fingerstick Blood Glucose Before..."
MEALS AND AT BEDTIME SLIDING SCALE:
121-150=2U, 151-200=3U, 201-250=6U,
251-300=9U, 301-350=12U, 351-400=15U...

Review of Resident #20's 4/10 MAR documented
the following significant medication errors:
  a. 4/10/10 at 11:30 AM-BS = 185, Novolog insulin
given 2U, correct dose 3U.
  b. 4/24/10 at 11:30 AM-BS =125, Novolin insulin
given 0, correct dose 2U.

8. Medical record review for Resident #21
documented an admission date of 9/19/07 with
diagnoses of Alzheimer's Disease and Diabetes
Mellitus. Review of the physician's recertification
orders dated 4/8/10 documented an order
initiated on 9/19/07 for "...FINGERSTICK BLOOD
GLUCOSE THREE TIMES A WEEK (MON
[Monday] - WED [Wednesday] - FRI [Friday])...
NOVOLIN R... SLIDING SCALE: >140=0U,
14-159=1U, 160-189=2U, 190= [2]19=3U,
220-249=4U, 250-279=6U, 280-309=8U,
310-339=7U, 340-369=8U, 370-399=9U, 400 OR
MORE=10U AND CALL MD AND USE FACILITY
DIABETIC PROTOCOL...."

During an interview in the conference room on
4/28/10 at 9:45 AM, the DON was asked how the
staff would know what to give for SSI based on
the SSI order initiated 9/19/07 for "...>140=0U,
14-159=1U..." The DON stated, "...should be a
clarification order..." After the interview, a
telephone order dated 4/28/10 was written which
documented "...Sliding Scale, Regular Insulin
<140 = 0 units, 140-159 = 1 unit [one unit]..."
There was one documented BS on 12/6/09 at
5:30 PM for which 1 unit of Novolin R was given.

Review of the 12/09 MAR documented the
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9. Closed medical record review for Resident #23 documented an admission date of 7/5/08 with diagnoses of Hemiplegia status post Cerebral Vascular Accident, Hypertension, Hyperlipidemia, Neurogenic Bladder, Breast Cancer, Diabetes Mellitus, and Diabetic Retinopathy. Review of hospital return order dated 2/11/09 documented "...Blood Glucose AC & HS..." A telephone order dated 2/13/09 documented ".Change Sliding Scale to the following: Regular R Insulin...121-150 = 1 unit; 151-200 = 2 units; 201-250 = 4 units, 251-300 = 6 units; 301-350 = 8 units; 351-400 = 10 units and notify MD..."

Review of Resident #23's 2/09 MAR documented the following significant medication errors:
a. 2/13/09 at 9:00 PM - BS = 341, Novolin R insulin given 10, correct dose 8U.
b. 2/14/09 at 11:30 AM - BS = 280, Novolin R insulin given 8, correct dose 6U.
c. 2/15/09 at 9:00 PM - BS = 341, Novolin R insulin given 10, correct dose 8U.
d. 2/18/09 at 9:00 PM - BS = 289, Novolin R insulin given 3, correct dose 6U.

10. Closed medical record review for Resident #24 documented an admission date of 10/15/08 with diagnoses of Hypertension, Diabetes Mellitus Type II, Cardiovascular Accident, Alcohol Abuse, Renal Insufficiency, Gastrointestinal Bleed and Myocardial Infraction. Review of the physician's orders dated 1/5/10 documented, "...NOVOLOG INSULIN...FINGERSTICK BLOOD GLUCOSE BEFORE MEALS AND AT BEDTIME SLIDING SCALE INSULIN 121-150 = 1U, 151-200 = 2U, ..."
Review of Resident #24's 1/10 MAR documented the following significant medication errors:

- a. 1/6/10 at 11:30 AM - BS = 122, Novolog insulin given 0, correct dose 1U.
- b. 1/6/10 at 9:00 PM - BS = 141, Novolog insulin given 0, correct dose 1U.
- c. 1/10/10 at 5:30 PM - BS = 159, Novolog insulin given 0, correct dose 2U.
- d. 1/11/10 at 5:30 PM - BS = 125, Novolog insulin given 0, correct dose 1U.
- e. 1/11/10 at 9:00 PM - BS = 128, Novolog insulin given 0, correct dose 1U.
- f. 1/15/10 at 5:30 PM - BS = 142, Novolog insulin given 0, correct dose 1U.
- g. 1/15/10 at 9:00 PM - BS = 140, Novolog insulin given 0, correct dose 1U.
- h. 1/16/10 at 11:30 AM - BS = 124, Novolog insulin given 0, correct dose 1U.
- i. 1/16/10 at 9:00 PM - BS = 142, Novolog insulin given 0, correct dose 1U.
- j. 1/18/10 at 9:00 PM - BS = 169, Novolog insulin given 0, correct dose 2U.
- k. 1/19/10 at 5:30 PM - BS = 148, Novolog insulin given 0, correct dose 1U.
- l. 1/20/10 at 5:30 PM - BS = 149, Novolog insulin given 0, correct dose 1U.
- m. 1/22/10 at 5:30 PM - BS = 143, Novolog insulin given 0, correct dose 1U.
- n. 1/22/10 at 9:00 PM - BS = 140, Novolog insulin given 0, correct dose 1U.
- o. 1/23/10 at 7:30 AM - BS = 122, Novolog insulin given 0, correct dose 1U.
- p. 1/23/10 at 11:30 AM - BS = 200, Novolog insulin given 0, correct dose 2U.
- q. 1/25/10 at 9:00 PM - BS = 128, Novolog insulin given 0, correct dose 1U.
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   r. 1/30/10 at 5:30 PM - BS = 133, Novolog insulin
given 0, correct dose 1U.

Review of Resident #24's 2/10 MAR documented
the following significant medication errors:

  a. 2/4/10 at 11:30 AM - BS = 147, Novolog insulin
given 0, correct dose 2U.
  b. 2/4/10 at 11:30 AM - BS = 151, Novolog insulin
given 0, correct dose 2U.
  c. 2/4/10 at 11:30 AM - BS = 149, Novolog insulin
given 0, correct dose 2U.
  d. 2/4/10 at 11:30 AM - BS = 141, Novolog insulin
given 0, correct dose 2U.
  e. 2/7/10 at 11:30 AM - BS = 132, Novolog insulin
given 0, correct dose 2U.
  f. 2/4/10 at 5:30 PM - BS = 149, Novolog insulin
given 0, correct dose 2U.
  g. 2/4/10 at 5:30 PM - BS = 141, Novolog insulin
given 0, correct dose 2U.
  h. 2/14/10 at 9:00 PM - BS = 147, Novolog insulin
given 0, correct dose 2U.
  i. 2/14/10 at 9:00 PM - BS = 145, Novolog insulin
given 0, correct dose 2U.
  j. 2/14/10 at 9:00 PM - BS = 145, Novolog insulin
given 0, correct dose 2U.
  k. 2/25/10 at 5:30 PM - BS = 132, Novolog insulin
given 0, correct dose 2U.

Review of Resident #24's 3/10 MAR documented
the following significant medication errors:

  a. 3/4/10 at 11:30 AM - BS = 131, Novolog insulin
given 0, correct dose 1U.
  b. 3/4/10 at 5:30 PM - BS = 192, Novolog insulin
given 0, correct dose 1U.
  c. 3/4/10 at 5:30 PM - BS = 150, Novolog insulin
given 0, correct dose 1U.
  d. 3/4/10 at 5:30 PM - BS = 151, Novolog insulin
given 0, correct dose 1U.
During an interview in the conference room on 4/28/10 at 2:30 PM, the DON was asked if the sliding scale insulin for Resident #24 was followed. The DON stated, "No."

11. Medical record review for Resident #25 documented an admission date of 8/16/05 with diagnoses of Congestive Heart Failure, Coronary Artery Disease, Diabetis, Weakness, Dementia, Hypertension, Chronic Obstructive Pulmonary Disease, Failure to Thrive, Cardiomyopathy, Pacemaker, Hypernatremia, Renal Insufficiency, Optic Neuropathy, Anemia, Depression. Review of the physician order dated 1/5/10 and recertification order dated 3/1/10, documented an order for FINGERSTICK BLOOD GLUCOSE TWICE EVERY DAY SLIDING SCALE: 0-150=0U, 151-200=3U, 201-250=6U, 251-300=9U, 301-350=12U, 351-400=15U, CALL MD...IF <70 OR >400...NOVOLOG INSULIN...SEE SLIDING SCALE AS NEEDED..."

Review of Resident #25's 1/10 MAR documented the following significant medication errors:

a. 1/19/10 at 5:30 PM - BS = 178, Novolog insulin given 2U, correct dose 3U.
b. 1/29/10 at 7:30 AM - BS = 151, Novolog insulin given 0, correct dose 3U.

Review of the 3/10 MAR documented the following significant medication error:

a. 3/15/10 at 7:30 AM - BS = 179, Novolog insulin given 0, correct dose 3U.

12. Medical record review for Resident #28 documented an admission date of 6/2/08 with diagnoses of Renal failure, Arthritis, Dementia,
F 333: Continued From page 81

Schizophrenia, Hypertension, Hypertension, and Diabetes Mellitus. The physician's order signed December 2009 and January 2010 documented an order for "...FINGERSTICK BLOOD GLUCOSE BEFORE MEALS AND AT BEDTIME... SLIDING SCALE: 150-200 = 4 U, 201-250=6 U, 251-300 = 8 U, 301-350 = 10 U, 31-400 = 12 U." A clarification order provided by the DON dated 4/28/10 documented "...BS of 351-400 = 12 U..." The facility staff failed to recognize and clarify the order from 12/09 through 4/28/10 with the physician, the incomplete sliding scale BS range for which 12 units of insulin would be administered.

Review of Resident #28's 1/10 MAR documented the following significant medication errors:
- a. 1/6/10 at 5:30 PM - BS = 250, Insulin given 8U, correct dose 6U.
- b. 1/13 at 9:30 PM - BS = 375, Insulin given 12U, no clarification of physician orders.
- c. 1/16/10 at 9:30 PM - BS 395, Insulin given 12U, no clarification of physician orders.

Review of Resident #28's 2/10 MAR documented the following significant medication errors:
- a. 2/1/10 at 9:30 PM - BS = 363, Insulin given 12U, no clarification of physician orders.
- b. 2/10/10 at 9:30 PM - BS = 372, Insulin given 12U, no clarification of physician orders.
- c. 2/10/10 at 5:30 PM - BS = 332, Insulin given 8U, correct dose 10U.
- d. 2/28/10 at 9:30 PM - BS = 211, Insulin given 4U, correct dose 6U.

Review of Resident #28's 3/10 MAR documented the following significant medication errors:
- a. 3/11/10 at 9:30 PM - BS = 200, Insulin given 0, correct dose 4U.
F 333: Continued From page 82

b. 3/20/10 at 9:30 PM - BS = 177, Insulin given 6U, correct dose 4U.

Review of Resident #28's 4/10 MAR documented the following significant medication errors:
   a. 4/14/10 at 11:30 AM - BS = 251, Insulin given 6U, correct dose 8U.
   b. 4/15/10 at 5:30 PM - BS = 235, Insulin given 4U, correct dose 6U.
   c. 4/19/10 at 9:30 PM - BS = 366 Insulin given 12U, no clarification of physician orders.

13. Medical record review for Resident #29 documented an admission date of 4/8/05 with diagnoses of Cerebral Vascular Accident, Dysphagia, Anemia, Hypertension, Hyperlipidemia, Insulin Dependent Diabetes Mellitus and Chronic Renal Insufficiency. Review of physician's recertification orders dated 1/9/10 through 4/8/10 documented an order initiated 10/8/08 for "...NOVOLIN R... SEE SLIDING SCALE AS NEEDED... SLIDING SCALE: 150-199=1U, 200-249=2U, 250-299=3U, 300=349=4U [300-349=4U], 35-300=5U, >400=6U AND CALL MD..." There was no physician clarification orders for the BS range for which 5 units of sliding scale insulin would be administered.

Review of Resident #29's 1/10 MAR documented the following significant medication error:
   a. 1/8/10 at 9:00 PM - BS = 168, Insulin given 0, correct dose 1U.

Review of Resident #29's 2/10 MAR documented the following significant medication errors:
   a. 2/5/10 at 8:00 PM - BS = 160, Insulin given 0, correct dose 1U.
   b. 2/8/10 at 8:00 PM - BS = 377, Insulin given 5U.
Review of Resident #29's 3/10 MAR documented the following significant medication errors:

- a. 3/7/10 at 8:00 PM - BS = 151, Insulin given 0, correct dose 1U.
- b. 3/12/10 at 8:00 PM - BS = 198, Insulin given 0, correct dose 1U.
- c. 3/22/10 at 8:00 PM - BS = 161, Insulin given 0, correct dose 1U.
- d. 3/24/10 at 8:00 PM - BS = 222, Insulin given 0, correct dose 2U.
- e. 3/26/10 at 8:00 PM - BS = 193, Insulin given 0, correct dose 1U.
- f. 3/27/10 at 8:00 PM - BS = 163, Insulin given 0, correct dose 1U.

During an interview in the hall outside Resident #29's room, on 4/28/10 at 7:45 PM, Nurse #6 was asked if a BS is 259, how much sliding slide insulin would you give. Nurse #6 stated, "3U." Nurse #6 was asked to read and explain the order from the MAR for (35-350=5U). Nurse #6 stated, "I think this should be 350 I need to call doctor and get order clarified."

14. Medical record review for Resident #30 documented an admission date of 5/30/08 with diagnoses of Renal Insufficiency, Pneumonia, Hypertension, Alcoholism, Congestive Heart Failure, Diabetes Mellitus, and Dementia. The April 2010 physician's recertification orders signed and not dated documented an order initiated 10/29/07 for "NOVOLOG INSULIN... SEE SLIDING SCALE AS NEEDED... SLIDING SCALE: 80-150=0U, 151-200=3U, 201-250=6U, 251-300=9U, 301-350=12U, 351-400=15U, <70 OR=400 NOTIFY MD..." and an order initiated 12/23/09 for "FINGERSTICK BLOOD"
F 333 Continued From page 84

GLUCOSE THREE TIMES EVERY DAY..."
Review of Resident #30's 3/10 MAR documented the following significant medication error:
a. 3/13/10 at 5:30 PM - BS = 207. Novolog insulin given 3U, correct dose 6U.

15. Medical record review for Resident #36 documented an admission date of 12/17/09 with diagnoses of Diabetes Mellitus, Peripheral Vascular Disease, Hypertension, Chronic Obstructive Pulmonary Disease, Cerebral Vascular Accident with Right Sided Weakness, and Cognitive Deficits. Review of the physician’s orders dated 4/7/10 with an initiated date 12/17/09 documented "...NOVOLIN R...FINGERSTICK BLOOD GLUCOSE BEFORE MEALS AND AT BEDTIME W/SLIDING SCALE-70-150=0U; 151-200=2U; 201-250=4U; 251-300=6U; 301-350=8U; 351-400=10U..."
Review of Resident #36’s 1/10 MAR documented the following significant medication errors:
a. 1/2/10 at 11:30 AM - BS = 146, Novolin R insulin given 2U, correct dose 0U.
b. 1/4/10 at 9:00 PM - BS = 333, Novolin R insulin given 10U, correct dose 6U.

Review of Resident #36's 3/10 MAR documented the following significant medication error:
a. 3/27/10 at 5:30 PM - BS = 274, Novolin R insulin given 0, correct dose 8U.

Review of Resident #36's 4/10 MAR documented the following significant medication error:
a. 4/8/10 at 11:30 AM - BS = 173, Novolin R insulin given 0, correct dose 2U.

16. During an interview in the conference room on 4/28/10 at 9:45 AM, the DON was asked who was responsible for reconciliation of physician's
F 333: Continued From page 85

...reclassification orders. The DON stated, "...11 to 7 [11:00 PM to 7:00 AM] shift... divided by three nurses... go through the telephone orders..." The DON stated that the management staff does audits on the reconciliation orders, but "...we don't keep them... we go over them... then they're destroyed..." On 4/28/10 at 11:30 AM, the DON came back to the conference room and stated, 

"...I have identified problems with reconciliation of orders... doctors orders... MARs... have come in on that shift and went over how to reconcile orders with one nurse..." The facility did not provide any documentation that the problems had been identified, and informed the survey team that they did not have a policy or protocol for reconciliation of orders.

During a telephone interview in the conference room on 4/29/10 at 9:40 AM, the Medical Director stated that he was not aware of any problems with the residents not getting their insulin dosages as ordered by the physicians, including himself.

17. During a telephone interview in the conference room on 4/29/10 at 10:48 AM, the Pharmacy Consultant (PC) was asked if he had observed medication administration with the staff. The PC stated, "...have not done one in that facility in the last quarter, I know..." The PC was asked what he looked at when he did a med pass. The PC stated, "...went to be sure meds are given in their window [time ordered]... right route... not leaving the MAR open... Insulin given in the room and not in the hall... whole list of things we look at... proper administration PEG [Percutaneous Endoscopic Gastrostomy tube] placement..." The PC stated, that he "...has not observed accuchacks or sliding scale insulin administered... review the MARs for accurate..."
Continued From page 86

"dose...", but "unless there's an issue...don't always look at [MAR].... spot check MARs and recertification orders... have not noticed any elevated blood sugars or blanks on the MARs..."

The PC stated that he was not aware of any problems with the reconciliation of recertification orders. The PC was asked if he checked the MARs. The PC stated, "...probably not this quarter..." The PC was asked if he participated in the quarterly QA meetings at the facility. The PC stated, "...sometimes attend quarterly meeting... haven't been in some time because they don't schedule them [QA meetings] when I am in the building..."

The facility must -

1. Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
2. Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:

1. Based on observations and interviews, it was determined the facility failed to follow proper kitchen sanitation as evidenced by out of date food in the cooler and the potential of backspashing of water on the pots and pans hanging above the sink.
2. The findings included:
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1. Observations during the initial kitchen tour on 4/25/10 at 6:39 AM, revealed pots and pans hanging above the sink with the potential for backspashing of water from the 3 compartment sink.

2. Observations during the initial kitchen tour on 4/25/10 at 6:45 AM, revealed the following:
   d. Diced pimento in a small bowl dated 4/21/10.

   During an interview in the kitchen cooler on 4/25/10 at 6:45 AM, the Dietary Manager (DM) stated, "...[orange juice, cucumber marinade and pimento cheese] should have been thrown away 4/23..." The DM was asked when the diced pimento should have been thrown away. The DM stated, "4/24."

F 425 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.
The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

This REQUIREMENT is not met as evidenced by:

1. Based on review of the Pharmacy Consultant and Vendor agreement, review of pharmacy consultant sheets, review of the "American Diabetes Association" website, policy review, review of facility control drug records, medical record review, observation and interview, it was determined the facility failed to ensure the pharmacy services assured accurate administration of medications, auditing and reconciliation of medical records such as physician's orders and Medication Administration Records (MAR) and consultation regarding administration of medications including sliding scale insulin to meet the residents needs for 19 of 40 (Residents #2, 8, 14, 17, 18, 20, 21, 23, 24, 25, 26, 27, 28, 29, 30, 31, 35, 36 and 37) sampled residents and Random Resident (RR #1). The Pharmacy's failure to monitor to assure blood sugars were obtained as ordered; antidiabetic medications were accurately administered in relation to blood sugar monitoring and physician orders placed Residents #2, 8, 14, 17, 18, 20, 21, 23, 24, 25, 26, 27, 28, 29, 30, 31, 35, 36 and 37 in immediate jeopardy (IJ). A conference was held in the conference room on 4/29/10 at 11:10 AM. The Administrator, Regional Nursing Consultant, and Regional Director of Clinical Services were notified of the findings that placed the diabetic residents in immediate jeopardy. The IJ effective
The findings included:

1. Review of the Pharmacy Consultant and Vendor agreement documented. "...The PHARMACY shall be responsible for the general supervision for FACILITY'S pharmaceutical services... c. Monthly reviews of the drug regimen of each patient [residents] with reports of any irregularities to the FACILITY'S nurse in charge and administrator... e. Recommendations, plans for implementation, and continuing assessment through dated, signed reports, which are given to and retained by the FACILITY for follow-up action and evaluation of performance... f. Written reports quarterly to the FACILITY on the status of FACILITY'S pharmaceutical service and staff performance... h. Providing and conducting programs of in-service education for professional staff of FACILITY which would enhance the effectiveness of the pharmaceutical services... 6. PHARMACY shall devote such time as may be necessary to carry out PHARMACY'S responsibilities..."

2. Medical record review revealed sampled Residents #2, 6, 8, 14, 17, 18, 20, 21, 23, 24, 25, 26, 27, 28, 29, 30, 31, 35, 36 and 37 had either elevated blood sugars (BS) or low BS without the physician being notified, had inaccurate dosages of sliding scale insulin administered, did not have accuchecks done as ordered, had medications administered without obtaining physician's orders, physician orders were not clarified, and physician orders were not followed. The pharmacist had not identified any of these issues. Refer to F157, F309 and F333.
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3. Review of the Consultant Pharmacist Review sheets for 1/10 to 3/10 documented "no issues."

4. During a telephone interview in the conference room on 4/29/10 at 10:48 AM, the Pharmacy Consultant (PC) was asked if he had observed medication administration with the staff. The PC stated, "...have not done one in that facility in the last quarter, I know..." The PC was asked what he looked at when he did a med pass. The PC stated, "...want to be sure meds are given in their window [time ordered]... right route... not leaving the MAR open... Insulin given in the room and not in the hall... whole list of things we look at... proper administration PEG [Percutaneous Endoscopic Gastrostomy tube] placement...". The PC stated, that he "...has not observed accuchecks or sliding scale insulin administered... review the MARs for accurate dose...", but "unless there's an issue... don't always look at [MAR]... spot check MARs and recertification orders... have not noticed any elevated blood sugars or blanks on the MARs...". The PC stated that he was not aware of any problems with the reconciliation of recertification orders. The PC was asked if he checked the MARs. The PC stated, "...probably not this quarter...". The PC was asked if he participated in the quarterly QA meetings at the facility. The PC stated, "...sometimes attend quarterly meeting... haven't been in some time because they don't schedule them [QA meetings] when I am in the building..."

483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all
F 431 Continued From page 91

controlled drugs in sufficient detail to enable an
accurate reconciliation; and determines that drug
records are in order and that an account of all
controlled drugs is maintained and periodically
reconciled.

Drugs and biologicals used in the facility must be
labeled in accordance with currently accepted
professional principles, and include the
appropriate accessory and cautionary
instructions, and the expiration date when
applicable.

In accordance with State and Federal laws, the
facility must store all drugs and biologicals in
locked compartments under proper temperature
controls, and permit only authorized personnel to
have access to the keys.

The facility must provide separately locked,
permanently affixed compartments for storage of
controlled drugs listed in Schedule II of the
Comprehensive Drug Abuse Prevention and
Control Act of 1976 and other drugs subject to
abuse, except when the facility uses single unit
package drug distribution systems in which the
quantity stored is minimal and a missing dose can
be readily detected.

This REQUIREMENT is not met as evidenced
by:

Based on review of a manufacturer's
specifications, observations and interviews, it was
determined the facility failed to ensure
medications were stored at proper temperatures,
that medications were not stored past their
expiration dates and failed to stored medications
Continued From page 92

F 431 in a locked compartment for 2 of 4 (Medication Cart #2 and #3) medication carts.

The findings included:

1. Observations of medication cart #3 at the Nurses’ Station on 4/27/10 at 11:35 AM, revealed three vials of Lorazepam injection in the control drug stock box with a notation, "REFRIGERATE" on the manufacturer’s label on each vial.

During an interview at the Nurses’ Station on 4/27/10 at 11:55 AM, Nurse #2 confirmed the three Lorazepam vials were not stored in the refrigerator per the manufacturer’s specifications on the label.

2. Observations at the Nurses Station on 4/27/10 at 12:00 PM revealed medication cart #2 contained the following:
   a. Two opened (removed from manufacturer’s moisture-protective foil overwrap) Advair Diskus. One Diskus had a hand written opening date of 2/11/10 with 30 remaining doses of 50. One Diskus had a hand written opening date of 3/18/10 with 24 remaining doses of 50.

   Review of a manufacturer’s specifications on the side of the Advair Diskus box documented, "Discard the Diskus 1 month after removal from the moisture-protective foil overwrap."

   During an interview at the Nurses Station on 4/27/10 at 12:15 PM, Nurse #3 confirmed the 2 Advair Diskus were out of date per the manufacturer’s specifications and Nurse #3 had administered one dose that morning.

3. Observation outside Room 608 on 4/28/10 at
CUMBERLAND MANOR NURSING CENTER

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<tr>
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<td>8:15 PM, revealed Nurse #8 left medication cart #2 unlocked, unattended and out of the nurses’ view.</td>
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| F 441 | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS |

- The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.
- (a) Infection Control Program:
  - The facility must establish an Infection Control Program under which it:
    1. Investigates, controls, and prevents infections in the facility;
    2. Decides what procedures, such as isolation, should be applied to an individual resident; and
    3. Maintains a record of incidents and corrective actions related to infections.
- (b) Preventing Spread of Infection:
  1. When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
  2. The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
  3. The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.
- (c) Linens:
  Personnel must handle, store, process and transport linens so as to prevent the spread of
F 441 Continued From page 94

infection.

This REQUIREMENT is not met as evidenced by:

Based on policy review, observation and interview, it was determined 2 of 8 (Nurse #1 and #6) nurses observed providing care failed to ensure infection control practices were used to prevent the potential spread of infection by not cleaning the accucheck instrument after use and not washing hands prior to instilling eye drops.

The findings included:

1. Review of the facility's "Eyedrop Administration Procedure for Adults" policy documented, "...4. Wash hands..."

Observations during the medication pass in room 202 on 4/27/10, Nurse #1 did not wash her hands prior to donning gloves and instilling an eye drop in Random Resident #1's eye.

During an interview outside resident room 202 on 4/27/10 at 7:50 AM, Nurse #1 verified that she did not wash her hands prior to instilling the eye drop in RR #1's eye.

2. Observations during the medication pass in the 300 hall on 4/28/10 at 9:35 PM, Nurse #6 obtained an accucheck on Resident #36. After obtaining the accucheck Nurse #6 placed the accucheck instrument on the top of the medication cart and then placed the accucheck instrument in the drawer without cleaning it.

F 490 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING

F 490

5/7/10
A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:

Based on review of "The American Diabetes Association" website, review of the "Drug Information Handbook for Nursing", policy review, review of facility control drug records, review of the Pharmacy Consultant and Vendor agreement, medical record review, observations and interviews, it was determined the facility's administration including the Administrator and the Director of Nursing (DON) failed to effectively and efficiently ensure that all residents were maintained at their highest practicable well-being.

The administrative staff failed to identify, monitor and follow-up on quality of care issues such as notifying the physician of elevated and/or low blood sugar (BS) levels. The administrator and DON failed to ensure the nurses notified the residents' physicians of elevated and/or low BS, the nurses obtained blood sugars as ordered, the nurses administered the correct insulin and insulin dosages according to the physician's orders, the nurses clarified incomplete physician orders for Sliding Scale Insulin (SSI), the nurses did not administer insulin without physician's orders which placed 20 of 24 (Residents #2, 8, 14, 17, 18, 19, 20, 21, 23, 24, 25, 26, 27, 28, 29, 30, 31, 35, 36 and 37) sampled residents identified by the facility as being insulin dependent diabetics in immediate jeopardy (UJ). The administrative staff failed to ensure the facility's
F 490 Continued From page 96

Quality Assurance (QA) program identified problem areas. The administrative staff failed to ensure the Consulting Pharmacist (CP) monitored, reviewed and identified concerns with medication administration and participated in the QA meetings. A conference was held in the conference room on 4/29/10 at 8:30 AM, at which time the Administrator and Director of Nursing (DON) were informed of the findings that placed the diabetic residents in U. The U effective date is 4/29/10, and is ongoing until the U is removed.

The findings included:

1. The administrative staff failed to ensure physicians were notified of low and/or elevated BS levels. The facility failed to notify the physician of a BS as high as 592 for Resident #27 on 2/7/10 at 5:30 PM. The facility staff failed to notify the physician of Resident #26's high BS levels such as 549 on 1/1/10 at 7:30 AM, 417 on 3/9/10 at 7:30 AM, 488 on 4/29/10 at 8:30 PM and failed to notify the physician of Resident #28's unknown BS when glucometer reading documented H (BS over 550) on 1/2/10, 1/6/10, 1/7/10 and 1/16/10 at 7:30 AM. The facility failed to notify the physician of Resident #20's low BS of 56 on 3/26/10. Refer to F157.

2. The administrative staff failed to ensure that residents were free of significant medication errors, that nursing staff administered the correct amount of insulin according to physician's orders, scale which placed diabetic residents in a serious and immediate threat to their health. The insulin dependent diabetics have the high likelihood of having hypoglycemia and hyperglycemia episodes by receiving the wrong insulin doses which placed 15 of 24 (Residents #2, 8, 14, 17, ...
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: 445202

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED: 04/29/2010

NAME OF PROVIDER OR SUPPLIER
CUMBERLAND MANOR NURSING CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
4343 ASHLAND CITY HWY
NASHVILLE, TN 37218

(ID) 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
(CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

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18, 20, 21, 23, 24, 25, 26, 28, 29, 30, and 36) sampled residents receiving insulin in immediate jeopardy. Refer to F333.

3. Review of the Consultant Pharmacist Review sheets for 1/10 to 3/10 documented "no issues."

The administrative staff failed to ensure the Consulting Pharmacist monitored, reviewed and identified concerns with medication administration, inserviced nurses, and participated in the QA meetings.

During a telephone interview in the conference room on 4/29/10 at 10:35 AM, the Consultant Pharmacist was asked if he had done medication (med) pass observations in this facility and whether he had identified any problems with med pass. The Consultant Pharmacist stated, "I have not done med pass observation in that facility..."

The CP was asked had he observed sliding scale insulin administration, and if he had observed any elevated blood sugars or blanks on the medication sheets. The CP stated, "I have not observed accuchek or sliding scale insulin administration... Have not noticed any elevated blood sugars or blanks on MAR [Medication Administration Record]..." The surveyor asked the CP when was the last time he checked the MAR. The CP stated, "I don't review MAR for accurate dose unless an issue, probably not checked this last quarter..." The CP was asked if he had attended the facility's QA meetings. The CP stated, "We sometimes attend QA Meeting, haven't been in some time cause they [facility] don't schedule it [QA] when I am in the building..."

The surveyor asked the CP if he was aware of any problems with the reconciliation of orders. The CP stated, "No..."
F 490 Continued From page 98

4. During a telephone interview in the conference room on 4/29/10 at 9:10 AM, the Medical Director was asked if he was aware of problems with medication administration. The Medical Director stated, “No.” The surveyor asked the Medical Director if medication administration issues had been discussed in QA. The Medical Director stated, “No…” Refer to F520.

5. The facility’s administration including the Administrator and the DON failed to effectively and efficiently develop and implement appropriate plans of action to correct quality deficiencies for care issues such as notifying the physician of high and low BS levels, failed to ensure there were no significant medication errors, failed to ensure the pharmacy consultant monitored medication administration and failed to ensure the Medical Director was aware of the problems with insulin administration and SSI physician orders. Refer to F157, F309 and F333.

F 501 483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR

The facility must designate a physician to serve as medical director.

The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility.

This REQUIREMENT is not met as evidenced by:
Based on review of the “American Diabetes Association” website, review of facility control
F 501  Continued From page 99

- drug records, policy review, review of the Medical Director agreement, medical record review,
  observations and interview, it was determined the facility failed to ensure the Medical Director was
  involved in the resident care policies, procedures, practices for administering medications including
  correct sliding scale insulin dosages, and ensuring the physicians were notified of a low
  blood sugar of 56 and elevated blood sugars greater than 350 to 400. The facility failed to
  inform the Medical Director of resident care issues to ensure the Medical Director coordinated
  medical care provided to ensure each resident maintained their highest practical well being when
  the facility staff failed to follow policy/procedures for medication documentation, follow physician
  orders, clarify physician orders, and/or obtain
  physician orders for 17 of 40 (1, 2, 8, 14, 17, 18, 19, 24, 25, 26, 28, 29, 30, 31, 35, 36, and 37)
  sampled residents and Random Resident (RR #1). The facility’s Medical Director failed to
  ensure that residents were free of significant medication errors; re-certification orders for
  sliding scale insulin (SSI) were accurately transcribed; nursing staff administered the correct
  amount of insulin according to the sliding scale and accurately and consistently administered
  “calculation based scales” (dosages) of sliding scale insulin in accordance with physician orders,
  and/or failed to obtain orders for insulin administration. The insulin dependent diabetics
  have the high likelihood of having hypoglycemia and hyperglycemia episodes by lack of physician
  notification of low or high blood sugars, by receiving the wrong insulin or the wrong insulin
doses. This resulted in immediate jeopardy for
16 of 24 (Residents #2, 8, 14, 17, 18, 20, 21, 23, 24, 25, 26, 27, 28, 29, 30, and 36) sampled
residents documented as insulin dependent. A
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conference was held in the conference room on 4/29/10 at 11:10 AM, the Administrator, Director of Nursing (DON), Assistant DON, Regional Administrator, Regional Nursing Consultant, and Regional Director of Clinical Services were notified of the findings that placed the diabetic residents in Immediate Jeopardy (IJ). The IJ effective date is 4/29/10, and is ongoing until the IJ is removed.

The findings included:

1. Review of the Medical Director agreement documented, "...Agreement 1. Engagement. The FACILITY hereby appoints and engages MEDICAL DIRECTOR, and MEDICAL DIRECTOR hereby accepts said appointment and engagement, to supervise, direct and be responsible for the medical care in the nursing home... 2. Term. The term of this Agreement shall be for the period commencing April 1, 2002 and shall continue on a month to month basis thereafter..." This agreement was signed by the Medical Director.

2. The facility failed to ensure the physician was notified of blood sugars below 50 and elevated blood sugars greater than 350 to 400 for 5 of 24 (Residents #18, 20, 23, 26 and 27) sampled residents that the facility had identified and documented as being insulin dependent. The failure to notify the physician of low and elevated blood sugars placed Residents #18, 20, 23, 26 and 27 in Immediate Jeopardy. Refer to F167.

3. The facility failed to ensure that residents were free of significant medication errors.

Re-certification orders for sliding scale insulin (SSI) were not accurately transcribed. The
nursing staff failed to administer medications as ordered including the correct amount of insulin according to the sliding scale, failed to accurately and consistently administer "calculation based scales" (dosages) of sliding scale insulin in accordance with physician orders, and/or failed to obtain orders for insulin administration. The insulin dependent diabetics have the high likelihood of having hypoglycemia and hyperglycemia episodes by receiving the wrong insulin or the wrong insulin doses. Administration and Pharmacy demonstrated no knowledge of the existing inconsistencies and errors in the administration of sliding scale insulin. Refer to F309 and F333.

4. During an interview in the conference room on 4/28/10 at 11:40 AM, the Director of Nursing (DON) confirmed the Medical Director was on the Quality Assurance (QA) committee. The DON was asked how often the QA committee met. The DON stated, "quarterly," The surveyor asked the DON what problems had been identified in the QA meeting. The DON stated, "physician order recertification and reconciliation."

During a telephone interview in the conference room on 4/29/10 at 10:10 AM, the surveyor asked the Medical Director if he was aware of any problems with medication administration, reconciliation of Medication Administration Record (MAR) or with problems with sliding scale insulin. The Medical Director stated, "No..."

When asked if problems with medication administration had been discussed in QA stated "No..."
A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:

Based on review of the "Drug Information Handbook for Nursing" 8th edition, review of the "American Diabetes Association" website, review of facility control drug records, policy review, medical record review, observations and interview, it was determined the facility failed to ensure the Quality Assessment (QA) and Assurance committee identified, developed and implemented plans of actions that addressed deficient quality care issues related to following, clarifying or obtaining physician orders for 17 of
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40 (1, 2, 8, 14, 17, 18, 19, 24, 25, 26, 28, 29, 30, 31, 35, 36, and 37) sampled residents and random resident (RR #1); notifying the physician of low and elevated blood sugars and/or medication administration of insulin for 19 of 24 (Residents #2, 8, 14, 17, 18, 19, 20, 21, 23, 24, 25, 26, 28, 29, 30, 31, 35, 36, and 37) sampled diabetic residents with sliding scale insulin (SSI); re-certification orders for SSI that were not accurately transcribed; failure of nursing staff to administer the correct amount of insulin according to the sliding scale, to accurately and consistently administer "calculation based scales" (dosages) of sliding scale insulin in accordance with physician orders, and/or obtain orders for insulin administration. The insulin dependent diabetics have the high likelihood of having hypoglycemia and hyperglycemia episodes by receiving the wrong insulin or the wrong insulin doses which placed them in immediate jeopardy (IJ). The QA committee had no documentation of any knowledge related to the problems with insulin administration. The IJ effective date is 4/29/10, and is ongoing until the IJ is removed.

The findings included:

1. Review of the "Drug Information Handbook for Nursing, 8th Edition", page 654 through (--) 651, documented "...Insulin Regular... High alert medication: The institute for Safe Medication Practices (SMP) includes this medication among its list of drugs which have a heightened risk of causing significant patient harm when used in error... Onset of action: 0.5 hours..."

2. Medical record review for Resident #26 documented physician's orders dated 1/5/10 for "...RINGERSTICK BLOOD GLUCOSE BEFORE..."
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MEALS AND AT BEDTIME... SLIDING SCALE:
WBG [blood glucose results] - [minus] 100
DIVIDED BY 50 = [amount of insulin to be
administered] # [number] OF UNITS [to be
administered] (calculated dose insulin) FOR
INSULIN > [greater than] 150... NOVOLIN R..."

Review of the 1/10 MAR documented 10
opportunities, from 1/1/10 through 1/7/10, with the
wrong calculated dose of insulin administered, 8
opportunities when the blood sugar (BS) was
>350 with no documentation the physician was
notified, and 5 of those registered as "HI [high]
(>350) on the glucometer. A hospital return order
dated 1/13/10 documented "...Nov [Novolin] R
[regular] 2 units AC [before meals] & [and] HS [at
bedtime]..." There was no order for accuchocks or
the sliding scale insulin to be given. There
were 26 opportunities, from 1/15/10 through
1/25/10, with insulin documented as being
administered, without a physician's order for
insulin, and 10 opportunities when the BS was
>350 with no documentation the physician was
notified, and 2 of those BS registered as "HI" on
the glucometer. Another hospital return order
dated 1/29/10 documented to obtain blood sugars
"AC & HS" with the calculated dose insulin to be
administered. There were 3 opportunities, from
1/30/10 through 1/31/10, with the wrong
calculated dose of insulin administered, and 1
opportunity when the BS was >350 with no
documentation the physician was notified.
Review of the 2/10 MAR documented 3
opportunities, from 2/1/10 through 2/2/10, with the
wrong calculated dose of insulin administered,
and 1 opportunity when the BS was >350 with no
documentation the physician was notified.
Resident #26 was hospitalized from 2/3/10
through 2/10, and returned with the same
accuchock and SSI orders. Review of the 3/10
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MAR documented 24 opportunities when the BS was >350 with no documentation the physician was notified, and one of those BS registered as "HI" on the glucometer. Review of the 4/10 MAR documented 25 opportunities with the wrong calculated dose of insulin administered, and 18 opportunities when the BS was >350 with no documentation the physician was notified.

Observations in Resident #26's room on 4/29/10 at 9:42 PM, revealed Nurse #8 obtained a BS of 488. Nurse #8 administered 2 units of Novolin R insulin to Resident #26, per a physician's order. The physician was not notified of the 488 BS.

During an interview at the nurses' station with the Director of Nursing (DON) present, on 4/28/10 at 10:12 PM, Nurse #8 was asked how he would calculate the dose of insulin. Nurse #8 stated, "...if it's point something [fraction] ...we round up or down... if 0.6 or 0.7 round up..." Nurse #8 was then asked if the fraction came out to be something point 5 would he round up or down. Nurse #8 stated, "...if it's 3.5 or 0.5 round down... I guess it would be up to the individual nurse..."

Nurse #8 was asked if he had had any inservice on how to use the calculated dose insulin, related to fractions of units. Nurse #8 stated, "No." The DON then stated, "...Yes, you have. Remember? If it's 0.5 what do you do?" Nurse #8 stated, "Round down." The DON rolled her eyes upward when Nurse #8 responded. The DON was then asked if that was what the nurses had been instructed in the inservice (to round down for 0.5). The DON stated, "...No...round up for something 0.5..."

3. Medical record review for Resident #2 documented a physician's hospital return order
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dated 1/5/10 for "...Accucheck BID [two times a day]..." Review of Resident #2's 1/10 Medication Administration Record (MAR) documented 5 opportunities with no documentation the BS was obtained. Review of the physician's orders dated 3/5/10 documented "...ACCUCHECKS AC & HS...c [with] S/S [sliding scale insulin]...NOVOLOG INSULIN...30i+ [to] 350 = 12U (units)...". Review of the 3/10 MAR documented 4 opportunities with the wrong dose of insulin administered. Review of the 4/10 MAR documented one opportunity with the wrong dose of insulin being administered, and 2 opportunities with no documentation the BS was obtained.

Observations in Resident #2's room on 4/2/10 at 8:40 PM, revealed Nurse #8 obtained a fingerstick blood sugar (BS) with results (=) of 327. Nurse #8 administered 7 units of Novolog insulin from a 100 unit syringe. Resident #2 should have received 12 units of Novolog for a BS of 327.

During an interview outside Resident #2's room on 4/28/10 at 8:40 PM, Nurse #8 stated, "...He [Resident #2] gets 6 [units], that's 5 [pointed to the 5 line on the syringe], so this is 6 [pointed to the line below the 5, which is 7 units]."

3. Medical record review for Resident #8 documented a physician's order dated 4/2/10 which included an order initiated on 1/26/10 for "...FINGERSTICK BLOOD GLUCOSE THREE TIMES EVERY DAY AND AT BEDTIME..." and an order initiated 6/11/09 for "...SLIDING SCALE...230-289=3U...". Review of the 2/10 MAR documented 1 opportunity with the wrong dose of insulin given, and 1 opportunity with no documentation the BS was obtained. Review of
the 3/10 documented 2 opportunities with no documentation the BS was obtained. Review of the 4/10 MAR documented 1 opportunity with no documentation the BS was obtained.

4. Medical record review for Resident #14 documented physician's orders dated 4/8/10 and initiated on 4/17/09 for "...FINGERSTICK BLOOD GLUCOSE TWICE A DAY...", and an order initiated 4/29/09 for "...SLIDING SCALE: 121-150=1U, 151-200=2U, 201-250=4U, 251-300=6U, 301-350=8U, 351-400=10U, < [less than] 70 OR > [greater than] 350 CALL MD [Medical Doctor]." Review of the 1/10 MAR documented 14 opportunities with the wrong dose of insulin administered, and 2 opportunities with no documentation the BS was obtained. Review of the 2/10 MAR documented 6 opportunities with the wrong dose of insulin administered. Review of the 3/10 MAR documented 3 opportunities with the wrong dose of insulin administered, and 2 opportunities with no documentation the BS was obtained. Review of the 4/10 MAR documented 1 opportunity with the wrong dose of insulin administered, and 4 opportunities with no documentation the BS was obtained.

5. Medical record review for Resident #17 documented a physician's orders dated 3/1/10 for "...NOVOLOG INSULIN... FINGERSTICK BLOOD GLUCOSE BEFORE MEALS AND AT BEDTIME W [with]/ SLIDING SCALE—0-120 = 0U; 121-150=2U; 151-200=3U; 201-250=4U; 251-300=6U; 301-350=12U; 351-400=15U AND CALL MD... If blood sugar is <60... recheck and if still <60... hold insulin... and immediately begin treatment... Repeat blood sugar in 30 minutes and if still <60... notify MD..." Review of the 12/09 MAR documented 2 opportunities with the wrong
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doctor of insulin administered. Review of the 1/10
MAR documented 1 opportunity with the wrong
doctor of insulin administered. Review of the 3/10
MAR documented 2 opportunities with the wrong
doctor of insulin administered.

6. Medical record review for Resident #18
documented physician's orders dated 4/12/10
with initial order date of 9/4/09 for
"...NOVOLOG INSULIN... SEE SLIDING SCALE
AS NEEDED... SLIDING SCALE: CALL MD
IMMEDIATELY FOR BLOOD SUGAR <60;
140-169=1U, 170-199=2U, 200-229=3U,
230-259=4U, 260-288=5U, 290-319=6U,
320-379=8U, 380-409=9U, 410-100U...". There
was no documentation of an order for when to
check the BS, and no documentation of a
clarification order for the "230359" range.

During an interview in the conference room on
4/28/10 at 9:45 AM, the Director of Nursing
(DON) was asked what should be done with an
order with a range of "230359". The DON stated,
"...[nurses] should have written a clarification
order..."

Review of Resident #18's 12/09 MAR
documented 4 opportunities with the wrong dose
of insulin documented, 3 opportunities when the
BS was >350 and there was no documentation
the physician was notified, and 4 opportunities
with no documentation the BS was obtained.
Review of the 1/10 MAR documented 2
opportunities with the wrong dose of insulin
administered, 9 opportunities when the BS was
>350 and there was no documentation the
physician was notified, and 5 opportunities with
no documentation the BS was obtained. Review
of the 2/10 MAR documented 6 opportunities with
the wrong dose of insulin administered. 19 opportunities when the BS was >350 and there was no documentation the physician was notified, and 3 opportunities with no documentation the BS was obtained. Review of the 3/10 MAR documented 6 opportunities with the wrong dose of insulin administered, 21 opportunities when the BS was >350 with no documentation the physician was notified, and 1 opportunity with no documentation the BS was obtained. Review of the 4/10 MAR documented 2 opportunities with the wrong dose of insulin administered, and 11 opportunities when the BS was >350 with no documentation the physician was notified.

Observations in Resident #18's room on 4/29/10 at 8:16 PM, revealed Nurse #11 obtained a BS of 383. Nurse #11 administered 8 units of Novolog insulin to the resident. The correct insulin dose was 9 units of Novolog insulin.

7. Medical record review for Resident #19 documented physician's orders dated 1/6/10 for "...FINGERSTICK BLOOD GLUCOSE BEFORE MEALS..." Review of the 1/10 MAR documented 1 opportunity with no documentation the BS was obtained. Review of the physician's orders dated 3/1/10 documented "...FINGERSTICK BLOOD GLUCOSE 730A AND 900P..." Review of the 3/10 MAR documented 2 opportunities with no documentation the BS was obtained. Review of the 4/10 MAR documented 3 opportunities with no documentation the BS was obtained.

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<th>251-300=9U, 301-350=12U, 351-400=15U...</th>
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<td>Review of the 4/10 MAR documented 2 opportunities with the wrong dose of insulin administered.</td>
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9. Medical record review for Resident #21 documented physician's orders dated 4/8/10 with an order initiated on 9/19/07 for "...FINGERSTICK BLOOD GLUCOSE THREE TIMES A WEEK... NOVOLIN R... SLIDING SCALE: > 140=0U, 14-159=1U, 160-189=2U, 190= [219-3U, 220-249=4U, 250-279=5U, 280-309=6U, 310-339=7U, 340-359=8U, 360-399=9U, 400 OR MORE=10U AND CALL MD AND USE FACILITY PROTOCOL...<70 or >350 [notify MD]..." A clarification telephone order dated 4/29/10, after the surveyor talked with the DON, documented "...Sliding Scale, Regular Insulin <140=0 units, 140-159 1 un [unit]..." Review of the 12/09 MAR documented 1 opportunity with the wrong dose of insulin administered. Review of the 3/10 MAR documented 1 opportunity when the BS was <70 with no documentation the physician was notified.

10. Closed medical record review for Resident #23 documented a physician's order dated 2/11/09 for "...Blood Glucose AC & HS c Reg [regular] S/S...Navolin R..." A telephone order dated 2/13/09 documented "...Regular R Insulin...121-150=1unit; 151-200=2units; 201-250=4 units; 250-300=6 units; 301-350-8units; 351-400 =10 units and notify MD..." Review of the 2/09 MAR documented 4 opportunities with the wrong dose of insulin administered, and 2 opportunities with no documentation the BS was obtained.

11. Closed medical record review for Resident #24 documented physician's orders dated 3/1/10...
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and an order initiated on 10/5/08 for

"...FINGERSTICK BLOOD GLUCOSE BEFORE
MEALS AND AT BEDTIME..." and an order
initiated 1/29/09 for "...SLIDING SCALE: 121-150
1U, 151-200=2U, 201-250=4U, 251-300=6U,
301-350=8U, 351-400=10U, AND CALL MD IF
<70 OR >350...". The order specified to use
Novolog insulin for sliding scale. Review of the
1/10 MAR documented 20 opportunities with the
wrong dose of insulin administered, 4
opportunities with no documentation the BS was
obtained, and 8 opportunities when the BS was
>350 with no documentation the physician was
notified. Review of the 2/10 MAR documented 11
opportunities with the wrong dose of insulin
administered, 2 opportunities with no
documentation the BS was obtained, and 2
opportunities when the BS was >350 with no
documentation the physicians was notified.
Review of the 3/10 MAR documented 5
opportunities with the wrong dose of insulin
administered, and 1 opportunity with no
documentation the BS was obtained.

12. Medical record review for Resident #25
documented physician's orders dated 1/5/10 for

"...FINGERSTICK BLOOD GLUCOSE TWICE
EVERY DAY... SLIDING SCALE: 0-150=0U,
151-200=3U, 201-250=6U, 251-300=9U,
301-350=12U, 351-400=15U, CALL MD IF <70
OR >400... NOVOLOG INSULIN...". Review of
the 1/10 documented 2 opportunities with the
wrong dose of insulin administered, and 2
opportunities with no documentation the BS was
obtained. Review of the 3/10 documented 1
opportunity with the wrong dose of insulin
administered.

13. Medical record review for Resident #28
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documented physician's recertification orders signed, but not dated, documented an order initiated on 6/2/08 for "...FINGERSTICK BLOOD GLUCOSE BEFORE MEALS AND AT BEDTIME... NOVOLOG INSULIN... SEE SLIDING SCALE AS NEEDED... SLIDING SCALE: 150-200=4U, 201-250=6U, 250-300=8U, 301-350=10U, 31-400=12U..." There was no clarification order obtained for the "31-400=12U" range until the DON was shown the order by the surveyor. A telephone clarification order was written on 4/29/10 for 351-400=12 units. Review of the 1/10 MAR documented 1 opportunity with the wrong dose of insulin administered. Review of the 2/10 MAR documented 2 opportunities with the wrong dose of insulin administered. Review of the 3/10 MAR documented 2 opportunities with the wrong dose of insulin administered. Review of the 4/10 documented 2 opportunities with the wrong dose of insulin administered.

14. Medical record review for Resident #20 documented physician's orders dated 1/9/10 through 4/8/10 and an order initiated on 10/9/08 for "...NOVOLIN R... SEE SLIDING SCALE AS NEEDED... SLIDING SCALE: 150-199=1U, 200-249=2U, 250-299=3U, 300=4U, 35-300=6U, >400=6U AND CALL MD..." There was no documentation of a clarification order for the "35-300=6U" range. Review of the 1/10 MAR documented 1 opportunity with the wrong dose of insulin administered. Review of the 2/10 MAR documented 1 opportunity with the wrong dose of insulin administered. Review of the 3/10 MAR documented 6 opportunities with the wrong dose of insulin administered.

16. Medical record review for Resident #30 documented physician's recertification orders,
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signed but not dated, and an order initiated
10/29/07 for "...NOVOLOG INSULIN... SEE
SLIDING SCALE AS NEEDED... SLIDING
SCALE: 80-150=0U, 151-200=3U, 201-250=6U,
251-300=9U, 301-350=12U, 351-400=15U, <70
OR >400 NOTIFY MD..." and an order initiated
12/23/09 documented "...FINGERSTICK BLOOD
GLUCOSE THREE TIME A DAY..." Review of
the 1/10 MAR documented 1 opportunity with no
documentation the BS was obtained. Review of
the 3/10 MAR documented 1 opportunity with the
wrong dose of insulin administered, and 1
opportunity with no documentation the BS was
obtained. Review of the 4/10 MAR documented 1
opportunity with no documentation the BS was
obtained.

16. Medical record review for Resident #31
documented physician's orders dated 1/9/10 for
"...FINGERSTICK BLOOD GLUCOSE tid [three
times a day] AT BEDTIME WITH SLIDING
SCALE..." A telephone order dated 2/24/10
documented "...[decrease] Fingersticks to BID
[two times a day] c S/S..." Review of the 1/10
MAR documented 4 opportunities with no
documentation the BS was obtained. Review of
the 2/10 MAR documented 3 opportunities with
no documentation the BS was obtained. Review
of the 3/10 MAR documented 1 opportunity with
no documentation the BS was obtained.

17. Medical record review for Resident #35
documented physician's orders dated 3/3/10 for
"...Accuchek AC & HS...s[s/ping scale]
150-199=1 unit 200-249=2 units 250-299=3 units
300-349=4 units 400=6 units call MD..." Review of
the 4/10 MAR documented 5 opportunities with
no documentation the BS was obtained.
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18. Medical record review for Resident #36 documented physician's orders dated 4/7/10 for:
   "...NOVOLIN R... FINGERSTICK BLOOD GLUCOSE BEFORE MEALS AND AT BEDTIME... SLIDING SCALE 70-150=0U;
   151-200=2U; 201-250=4U; 251-300=6U;
   301-350=8U; 351-400=10U..." Review of the 1/10 MAR documented 2 opportunities with the wrong dose of insulin administered, and 2 opportunities with no documentation the BS was obtained. Review of the 2/10 MAR documented 6 opportunities with no documentation the BS was obtained. Review of the 3/10 MAR documented 1 opportunity with the wrong dose of insulin administered, and 3 opportunities with no documentation the BS was obtained. Review of the 4/10 MAR documented 1 opportunity with the wrong dose of insulin administered.

19. Medical record review for Resident #37 documented physician's orders dated 1/5/10 for:
   "...[handwritten on recertification orders]
   12/23/09...FBG [fingerstick blood sugar] [check]
   TID [three times a day]... NOVOLING INSULIN... FINGERSTICK BLOOD GLUCOSE BEFORE MEALS AND AT BEDTIME WITH SLIDING SCALE 150-199=1U; 200-249=2U;
   250-299=3U; 300=4U; 349=4U; 350-399=5U; >400=6U AND CALL MD..." There was no clarification order documented to clarify how often to do the FSB. Review of the 1/10 MAR documented 3 opportunities with no documentation the BS was obtained. Review of the 2/10 MAR documented 2 opportunities with no documentation the BS was obtained. Review of a telephone order dated 2/24/10 documented "...D/C [discontinue] accuchek QID [four times a day]... [charge] to BID..." Review of the 3/10 MAR documented 1 opportunity with no
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documentation the BS was obtained.

20. During an interview in the conference room on 4/28/10 at 11:40 AM, the Director of Nursing (DON) confirmed the Medical Director was on the Quality Assurance (QA) committee. The DON was asked how often the QA committee met. The DON stated, "quarterly." The surveyor asked the DON what problems had been identified in the QA meeting. The DON stated, "physician order recertification and reconciliation."

21. During a telephone interview in the conference room on 4/29/10 at 9:40 AM, the Medical Director was asked if he participated in the QA meetings. The Medical Director stated that he does attend the quarterly QA meetings. The Medical Director was then asked if he was aware if the facility had identified any problems through the QA process with insulin doses, such as missed doses, wrong doses, etcetera (etc). The Medical Director stated that he did not remember that being identified by the facility as a concern.

22. During a telephone interview in the conference room on 4/29/10 at 10:48 AM, the Pharmacy Consultant (PC) was asked if he had done any medication passes with the staff. The PC stated, "...have not done one in that facility in the last quarter, I know..." The PC was asked what types of things he looks at when he does a med pass. The PC stated, "...want to be sure meds are given in their window [time ordered]... right route... not leaving the MAR open... Insulin given in the room and not in the hall... whole list of things we look at... proper administration PEG [Percutaneous Endoscopic Gastrostomy tube] placement... handwashing." The PC further...
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stated, that he "...has not observed accuchacks or sliding scale insulin administered... review the MARs for accurate dose...", but "unless there's an issue... don't always look at [MAR]... spot check MARs and recertification orders... have not noticed any elevated blood sugars or blanks on the MARs..." The PC stated that he was not aware of any problems with the reconciliation of recertification orders. The PC was asked if he checked the MARs. The PC stated, "...probably not this quarter..." The PC was asked if he participated in the quarterly QA meetings at the facility. The PC stated, "...sometimes attend quarterly meeting... haven't been in some time because they don't schedule them when I am in the building..."

23. The Quality Assessment and Assurance Committee failed to identify, develop and implement a plan of action to ensure physician orders were followed and/or obtained for medication/treatments; physicians were notified of low and/or elevated blood sugars; insulin dosages were calculated and fractions were rounded consistently and that correct doses of insulin were administered.

Refer to F157, F309, and F333.