<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION)</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>N 609</td>
<td>1200-8-6- 05(4)(c)(4) Basic Services (4) Nursing Services (c) The Director of Nursing shall have the following responsibilities: 4. Notify the resident's physician when medically indicated</td>
<td>1. Residents #18, 19 medication and accucheck flow sheets for the month of July were reviewed for documentation of abnormal blood glucose levels. The resident's attending physicians were notified of any abnormalities as indicated. 2. Record review of all residents with documented diagnosis of DM and ordered accuchecks will be completed to verify MD notification of abnormal levels by DNS, RN Supervisors or Compliance Nurse. 3. All nursing staff will be inserviced as to proper documentation and MD notification guidelines concerning blood glucose monitoring. 4. Record review will continue daily x 2 weeks, then weekly x 2 months, then monthly ongoing as warranted with pertinent findings reported to DNS/ADNS for 1:1 counseling and/or disciplinary action as indicated. Pertinent findings will be tracked by DNS and reported to the QA committee monthly ongoing and as warranted.</td>
<td>7/1/08, 7/11/08, 7/23/08</td>
</tr>
</tbody>
</table>

This Rule is not met as evidenced by: Type C Pending Penalty #4

Based on policy review, medical record review, and interview, it was determined the facility failed to ensure the physician was notified of elevated blood sugars for 2 of 24 (Residents #16 and 19) sampled residents

The findings included:

1. Review of the facility's "Nursing Care of Resident with Diabetes Mellitus" policy documented, "Licensed nursing staff will notify the attending physician or on call physician when a resident's glucose level is equal to or greater than 400mg/dl [milligrams per deciliter] for high unless otherwise specified by individual physician order."

2. Medical record review for Resident #16 documented an admission date of 5/2/07 with diagnoses of End Stage Renal Disease, Dialysis, Depression, Hypertension, Hepatitis C, Anemia, Sarcoidosis, Neuropathy, and Diabetes Mellitus. Review of a physician's order initiated 8/1/07 documented "...ACCUCHECKS BEFORE MEALS AND AT BEDTIME WITH SSI [sliding scale insulin] COVERAGE. See flow sheet for
N669 continued from page 1

Review of Resident #16's blood sugar flow sheet for April 2008 documented 30 blood sugars (BS) greater than 351. The blood sugars greater than 351 ranged from 380 to HI (greater than 500)

Review of the blood sugar flow sheet for May 2008 documented 20 BS greater than 351. The blood sugars greater than 351 ranged from 352 to HI. Review of the blood sugar flow sheet for June 2008 documented 8 BS greater than 351.

The blood sugars greater than 351 ranged from 388 to HI. There was no documentation of the physician being notified of the elevated blood sugars in April and May 2008. The physician was notified of the elevated blood sugars on 6/17/08 at 4:00 PM and 6/21/08 at 8:45 PM but was not notified of the other elevated blood sugars in June 2008.

N 669: Continued From page 2

documented 6/28/08 a blood sugar result of 369
There was no documentation the physician was
notified of this elevated blood sugar

During an interview in the conference room on
7/2/08 at 5:45 PM, the Director of Nursing stated,
"There is no documentation the MD was notified
of the 6/28/08 elevated blood sugar"

N 728: 1200-6-6-06(6)(b) Basic Services

(6) Pharmaceutical Services:

(b) Such cabinets or drug rooms shall be kept
securely locked when not in use, and the key
must be in the possession of the supervising
nurse or other authorized persons.

This Rule is not met as evidenced by:
Type C Pending Penalty #7

Based on review of the medication guide for the
long-term care nurse, observations and interview,
it was determined the facility failed to ensure
medications were stored in locked compartments
at all times for 1 of 5 (Resident #4) observed
during the medication administration pass.

The findings included:

Review of the medication guide for the long-term
care nurse, sixth edition page 67 documented,
"...Patient medications should not be left on top of
the medication cart."

Observations on the East back hall on 7/1/08 at
8:15 AM, revealed Licensed Practical Nurse
(LPN) #3 administered an Advair Diskus to
Random Resident (RR) #4. After administering

1. All medication carts were verified to be
   secured when unattended. 7/2/08
2. Medication carts will be stored in designated
   areas when not in use and secured by
   medication nurse at all times when
   unattended.
3. All nursing staff will be inserviced as to
   proper storage of medication and security of
   medication carts when unattended.
4. The pharmacy nurse, compliance nurse or
   pharmacy consultant will observe random
   medication carts for proper security when
   unattended weekly x 1 month, then monthly
   ongoing as warranted. Pertinent findings will
   be reported to DNS/ADNS for 1:1
   counseling and/or disciplinary action or
   re-education as indicated. Pertinent findings
   will be reported to the QA committee
   monthly as warranted for review.
<table>
<thead>
<tr>
<th>N 728</th>
<th>Continued From page 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>the inhaler to RR #4, LPN #3 placed the Advair Diskus on the medication cart and proceeded to go into the bathroom in RR #4's room to wash her hands. The medication cart was not in LPN #3's view while she was in the bathroom</td>
</tr>
</tbody>
</table>