DEPARTMENT OF HEALTH AND HUM... SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 5/16/
FORM APPROVE
2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A066	A. BUILDING ____ B. WING ____	5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLA CARE CENTER	3094 SOUTH STATE STREET SALT LAKE CITY, UT 84165

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 224 SS=J	483.13(c)(1)(i) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. (Use F224 for deficiencies concerning mistreatment, neglect or misappropriation of resident property.) This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that a licensed nurse provided necessary cares and services to a unresponsive resident with a low blood glucose level. Specifically, a licensed nurse failed to activate emergency medical systems (EMS) when initial nursing assessment and interventions did not result in an improvement in the residents condition. (Resident CR1.) Findings include: Resident CR1 was a 41 year old male admitted to the facility on 8/20/01, with diagnoses of diabetes mellitus type I, hypoglycemic seizures, chronic obstructive pulmonary disease, aspiration pneumonia, history of respiratory failure, history of pancreatitis and alcoholic cirrhosis with varices. A review of resident CR1's medical record was completed on 5/10/02. On 11/2/01, facility staff completed a care plan for resident CR1. Facility staff documented resident CR1 had a problem with unstable blood glucose levels,which required blood glucose monitoring, and that the resident had a history of alteration in level of consciousness. The contributing factors to these problems were documented as a history of difficulty controlling blood glucose and a history of non-compliance. The care plan goals for	F 224	CR1 was discharged to hospital on 03/06/2002 All residents with a change of condition will follow the change of condition policy. (see attached) Written policies have been developed outlining protocol to follow when change of condition exists. These policies address hypoglycemic, hyperglycemic, and non-responsive residents Protocol identifies when to notify the physician and/or emergency medical services. Appropriate nursing staff have been in-serviced. Orientation process has been modified to ensure new nursing staff fully understands these policies. The Director of Nursing will monitor the orientation process to ensure that all new nursing staff fully understands emergency protocol. Director of Nursing will monitor the change of condition report daily, during the week and by phone on the weekends to be informed of any change, and report status to the administrator and the Quality Assurance Committee	5/13/02

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Michael [signature] | TITLE Administrator | (X6) DATE 5-16-2002

Utah Dept. of Health
MAY 21 2002
Bur. of Medicare/Medicaid Prog. Certification and Res. Assessment
#499869 #7

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days aft such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 224	Continued From page 1 these identified problems were that his blood glucose level would remain within normal limits, that he would not go into a diabetic coma, and that he would not have an insulin reaction. The interventions were that nursing would monitor blood glucose levels, observe for signs and symptoms of hyperglycemia and to report significant changes to the doctor. Resident CR1's medical record contained nursing notes, as well as weight/skin condition review records, which documented that on 10/15/01, the resident was found to be unresponsive and that the facility staff had called 911. Resident CR1 had a five day stay at an acute care hospital and was intubated, following that change in condition. Resident CR1 had a medical treatment plan, signed and dated 11/5/01, which documented the resident desired full medical treatment in the event of an emergency and did not want a Do Not Resuscitate (DNR) order written. A review of resident CR1's medical record was completed on 5/8/02. The following was documented in resident CR1's nursing notes on 3/6/02, by employee 1, "0530 Pt [patient] unresponsive. BS [blood sugar/blood glucose] - 42 Frothing at mouth. Glucagon IM [intramuscularly] given. 0600 - BS - 52. Sugar placed under tongue. BS at 0630 - 80 Pt is still unresponsive. [Attending physician] called. Transport to [acute care hospital]. 0710 Paramedics here to transport to hospital." "0655 Late entry. Checked BS - 79. Pt opened eyes when name called then appeared to return to sleep. . . ." It is noted that the paramedics were not called by employee 1. On 5/8/02 at 11:30 AM, an interview was held with employee 2 , a facility Licensed Practical Nurse (LPN). Employee 2 stated she arrived at the facility, for work, on 3/6/02 around 7:00 AM. She stated when she arrived at the facility, two nurse aides came to her	F 224		

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F 224	Continued From page 2 and told her that resident CR1 "was not well". She further stated she immediately went to resident CR1's room, assessed his condition, and found him to be unresponsive. Employee 2 stated she then went to the medication room where she found the night LPN (employee 1). Employee 2 stated employee 1 reported he had already administered Glucagon and that he had attempted to call the doctor. Employee 2 stated she immediately called 911 and attempted to contact the doctor again. A review of employee 1's time card was done on 5/8/02. Employee 2 clocked in at 6:55 AM on 3/6/02. An interview was held with a nurse aide on 5/10/02 at 8:00 AM. This nurse aide stated she worked the graveyard shift on 3/6/02, when resident CR1 was found to be unresponsive. The nurse aide stated about 5:00 AM she heard a noise in resident CR1's room. When she went to determine the source of the noise she found resident CR1 unresponsive and that she shook his arm in an attempt to wake him up. She stated he did not respond. The nurse aide stated she immediately went to employee 1 to report resident CR1's condition. The nurse aide stated employee 1 came to resident CR1's room and stated, "It was just a seizure." The nurse aide stated she told employee 1 that he should check the resident's blood glucose level. The resident's blood glucose level was checked and found to be 42. The nurse aide stated employee 1 administered a glucose shot and rechecked the resident's blood glucose level about 20 minutes later. The nurse aide stated the resident's blood glucose level had come up some, but not much and the resident remained unresponsive and was "flailing" his arms. The nurse aide stated employee 1 was "too casual", stating resident CR1 was "coming slowly around". The nurse aide stated employee 1 then began to pass medications to other residents. The nurse aide stated she remained in resident CR1's room. The nurse aide	F 224		

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F 224	Continued From page 3	F 224		

stated employee 1 instructed her to place sugar under the resident's tongue even though the resident was unresponsive. The nurse aide stated she was uncomfortable with the instruction but felt compelled to comply because, "He's the nurse." The nurse aide stated she attempted to place the sugar under the resident's tongue but the sugar just fell back out of his mouth.

The nurse aide stated employee 1 left a message on the facility's Director of Nursing's answering machine. The nurse aide stated employee 1's message did not include any information regarding resident CR1's condition or a sense of urgency, only that the DON call the facility.

The nurse aide stated she reported resident CR1's condition to employee 2, when she arrived at the facility around 7:00 AM. The nurse aide stated employee 2 immediately went to resident CR1's room, assessed the resident's condition and called 911. The nurse aide stated about 10 minutes later the paramedics arrived. The nurse aide stated that although she is a nurse aide in this country, she was a licensed nurse in her native country.

On 5/10/02 at 2:10 PM, an interview was held with resident CR1's attending physician. The physician stated she believed resident CR1 did not receive appropriate treatment on 3/6/02, the day he was transported to the hospital. The physician stated that resident CR1 died within a few days after being transported to the hospital. She stated she felt the facility nurse neglected to provide timely intervention, including calling 911. The physician stated that although she was not involved in the resident acute care hospitalization treatment, she felt it likely that employee 1's negligence on the morning of 3/6/02 contributed to the resident's death.

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F 224	Continued From page 4	F 224		
F 253 SS=B	483.15(h)(2) ENVIRONMENT The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, the facility did not provide housekeeping and maintenance services necessary to maintain a sanitary environment as evidenced by, a wet floor in a bathroom, two open windows without screens, and a door which had about 1/8th of an inch space underneath and opened to the outside. findings include: 1. On 5/7/02 at 3:00 PM, it was obsereved that the downstairs bathroom had a wet floor that measured about 4 feet by 2 feet from the toilet towards the entrance. The floor was also noted to be wet on the mornings of 5/8/02 and 5/9/02. 2. On 5/7/02 at 11:00 AM, it was observed, in the employee breakroom, that two windows had no screens on them and were open to the outside. This provided a possible avenue for insects and other pests to come into the facility. It was also noted on 5/8/02. Residents were observed to come down to the employee breakroom area at various times of the day on 5/7/02 and 5/8/02. 3. On 5/8/02 at 8:00 AM, it was observed that the dinning room door to the outside had about 1/8th of an inch space at the bottom which provided a possible avenue for insects.	F 253	1. Water valves on bathtub adjusted to prevent leaking. 2. Screens have been applied to the windows. 3. Weatherstrip applied to bottom of dining room door. Housekeeping supervisor will monitor monthly and report status to the Administrator and the Quality Assurance Committee	5/17/2002
F 287 SS=B	483.20(f)(1-4) Resident Assessment	F 287		

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F 287	Continued From page 5 Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: Admission assessment; Annual assessment updates; Significant change in status assessments; Quarterly review assessments; A subset of items upon a resident's transfer, reentry, discharge, and death; Background (face-sheet) information, if there is no admission assessment; Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the State information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by HCFA and the State. A facility must electronically transmit, at least monthly, encoded, accurate, complete MDS data to the State for all assessments conducted during the previous month, including the following: Admission assessment; Annual assessment; Significant change in status assessment; Significant correction of prior full assessment; Significant correction of prior quarterly assessment;	F 287	Discharge tracking form was completed and transmitted for the residents identified. Resident roster report will be run monthly and checked to ensure that all discharged residents have been cleared from system. Office manager will monitor and report status to the administrator and the Quality Assurance Committee.	5/10/2002

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F 287	Continued From page 6 Quarterly review; A subset of items upon a resident's transfer, reentry, discharge, and death; Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment. The facility must transmit data in the format specified by HCFA or, for a State which has an alternate RAI approved by HCFA, in the format specified by the State and approved by HCFA. This REQUIREMENT is not met as evidenced by: Based on review of the facility's current resident roster, and the "Center for Medicare and Medicaid Services (CMS) State - End of Month Roster Report" for March 2002, it was determined that the facility did not encode or transmit Minimum Data Set (MDS) discharge tracking forms to the State database for 6 discharged residents that were listed on the CMS State - End of Month Roster Report. Resident identifiers: CR2, CR3, CR4, CR5, CR6, and CR7. Findings include: On 5/06/02, the facility's current resident roster and the CMS State Report (a report that documents the MDS assessments that were encoded and transmitted by the facility), dated March 2002, were reviewed. Residents who were listed on the CMS State Report for a facility were either current or former residents at that facility. The names of former residents remained on the CMS State Report for the facility until their discharge had been documented by the facility on an MDS discharge tracking form. This record review revealed that 6 residents listed on the CMS State	F 287		

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F 287	Continued From page 7 Report were not listed as residents on the facility's current resident roster and did not have their MDS discharge tracking forms transmitted. A list of the discharged residents with their past target date (in accordance to the facility's CMS report) are listed as follows: CR2 7/28/99 CR3 4/26/01 CR4 7/05/01 CR5 11/10/99 CR6 11/25/98 CR7 9/30/98	F 287		
F 354 SS=E	483.30(b)(1)-(3) NURSING SERVICES Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and review of the May 2002, licensed employee schedule, it was determined that the facility did not use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Findings include: On 5/9/02 at 2:45 PM, an interview was conducted with the Director of Nursing (DON). She stated that	F 354	The Director of Nursing will ensure that the facility uses the services of an RN at least 8 consecutive hours per day, 7 days a week. Arrangements have been made with nurse employment agency for temporary R.N. staffing. We have placed and advertisement in a local newspaper to recruit R.N. for weekend coverage. Director of Nursing will monitor and report status to the administrator and the Quality Assurance Committee	5/20/2002

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F 354	Continued From page 8 she was the only registered nurse on the schedule and she routinely worked only Monday through Friday. She also stated that she was unaware of any regulation requiring a registered nurse to work the 8 consecutive hours, 7 days a week. A review of the licensed employee schedule for the month of May 2002, was done on 5/9/02. It revealed that there were no other registered nurses on the schedule and that there was no weekend registered nurse coverage.	F 354		
F 371 SS=E	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation, the facility did not store food under sanitary conditions as evidenced by not dating items stored in the fridges and freezer, single use storage containers being used to store left-overs and disrepair of the kitchen. Findings include: 1. On 4/6/02 at 2:25 PM, it was observed in the refrigerator by the dishwasher, there was a shriveled green pepper, cheese, tortillas and sliced tomatoes that were not dated. In the freezer, by the south door, there was some bacon in which the package had been opened and no date was on the package. 2. On 5/7/02 at 12:45 PM, it was observed that there were two health shakes in the fridge, by the south door, which had not been dated. The label documented that the product was to be discarded 14 days after it had been thawed.	F 371	1. All open food items have been dated. Dietary manager has in-serviced all dietary staff on the requirement for proper dating of open food and disposal of expired food items. 2. Health shakes will be dated when removed from the freezer and disposed of after 14 days. Dietary manager has in-serviced all dietary staff on the requirements for proper dating of open food and disposal of expired food items. 3. No single use containers will be used for storage of food items. Dietary manager has in-serviced all dietary staff on proper use of storage containers. 4. The edge of the board has been smoothed and painted to allow for sanitation.	5/29/2002

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F 371	Continued From page 9 3. On 4/6/02 at 2:30 PM, it was observed in the fridge, by the south door, there were two single-use cottage cheese containers that were being used for storage; one had teriyaki sauce in it and the other had ketchup. 4. On 5/7/02 at 12:30 PM, it was observed by the fridge, next to the dishwasher, there was a board which was 2.5 feet long by 1 inch. The edge of the board was bare and rough which made it unsanitizable. In the window seal by the dishwasher there were three chips in the ceramic tile which measured about one inch each. The ceiling air vent, above where the tray line, had dust in and around it and there was dust accumulation between the fridges by the south door. The paper towel dispenser, by the dishwasher, was coming off the wall and was hanging by only one screw. The cupboards under the sink, by the dishwasher, were missing doors.	F 371	The ceramic tile on the windowsill has been removed and replaced with a painted wooden sill. The ceiling vent has been cleaned and the dust removed between the fridges by the south door. The paper towel dispenser has been remounted. Doors have been mounted over the cupboards under the sink. Dietary manager will monitor kitchen area for compliance with all sanitary issues affecting kitchen. The Dietary manager will make a written bi-monthly checklist and will report the status to the Administrator and the Quality Assurance Committee monthly.	
F 426 SS=K	483.60(a) PHARMACY SERVICES 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. This REQUIREMENT is not met as evidenced by: Based on review of Medication Administration Records (MARs), nursing notes, and physician orders, it was determined that for 4 of 10 sampled residents plus 2 supplemental residents the facility failed to ensure that pharmaceutical services for residents with diabetes mellitus (including insulin administration) were provided to meet the needs of each resident. (Residents 2, 7, 11, 31, 35 and CR1.) During the recertification survey, ending 5/10/02, six residents with diabetes mellitus resided in the facility.	F 426	F426 Residents 2,7,11,31,35 has had their pharmaceutical services reviewed and changed to accurately meet their diabetic mellitus, including insulin administration needs. All future residents will follow the new policies that were put in place on 05/13/2002.	

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F 426	Continued From page 10 Insulin administration errors were identified for 5 of the 6 residents, plus one discharged resident. The insulin administration errors included: 1. Failure to notify the attending physician when directed to do so by insulin orders; 2. Failure to administer regularly scheduled and sliding scale insulin; 3. Failure to administer accurate dosage of regularly scheduled and sliding scale insulin; and, 4. Failure to monitor blood glucose levels prior to administering insulin. Findings include: 1. Resident 31 was admitted to the facility on 9/17/01, with diagnoses including diabetes mellitus type II and diabetic neuropathy. A review of physician orders for resident 31 was completed on 5/10/02. On 9/19/01, facility staff obtained a physician telephone order to monitor resident 31's blood glucose level two times a day. On 9/25/01, resident 31's physician ordered the blood glucose monitoring to increase to four times a day. Resident 31's physician adjusted the resident's insulin orders between 9/26/01 and 1/16/02. On 1/16/02, resident 31's physician changed the resident's morning dose of NPH insulin to 6 u (units). Although resident 31's physician prescribed several one time orders for insulin, based on the resident's blood glucose level, the resident's scheduled morning dose of NPH insulin remained at 6 u through 5/10/02. A review of resident 31's nursing notes, between 3/5/02 and 5/10/02 was completed on 5/10/02. On 3/5/02, a nurse documented, "Med error - Wrong insulin dosage (60 u NPH) given - Physician notified - Pt [patient] to [acute care hospital] per ambulance per	F 426	1. Nurse will notify the attending physician when directed to do so by insulin orders. 2. Nurse will administer regularly scheduled and sliding scale insulin. 3. Nurse will administer accurate dosage of regularly scheduled and sliding scale insulin. 4. Nurse will monitor blood glucose levels prior to administering insulin. The quality assurance committee has met and reviewed the format for documentation of blood glucose monitoring and insulin administration. The format on the medication record has been modified to allow for easier documentation and more clear and concise charting. Policies have been developed covering medication administration, physician notification, and emergency procedures for adverse insulin reaction. Appropriate nursing staff have been in-serviced on these policies. The nurses at shift change review the entries for the previous shift for complete and accurate documentation.	5/13/2002

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F 426	Continued From page 11 phys. [physician] order. BS [blood sugar/blood glucose] 135 [at] departure. Pt alert [and] oriented. Syringe read as 6.0 instead of 60. On 3/7/02, a nurse documented that resident 31 returned from the acute care hospital. The nurse who documented the medication error in the 3/5/02 nursing note entry also documented an Incident/Accident Report and a Medication Error Report for the insulin administration error that occurred with resident 31. These two reports were dated 3/5/02. The nurse documented on the Medication Error Record that resident 31 was administered 60 u insulin and that the order was for 6 u insulin. The nurse documented the reason for the error as, "Misread syringe". The nurse documented on the Incident/Accident Report, "Incorrect insulin Dosage Given." The Incident/Accident Report form included an entry, "Length of time in this position", to which the nurse documented one hour. An interview has held with the Director of Nursing on 5/10/02 at 8:25 AM. The DON was asked about the insulin administration error involving resident 31, which occurred on 3/5/02. The DON stated the nurse administered 60 u of NPH insulin instead of 6 u. The DON stated it was that nurse's first day of orientation when the incident occurred. The DON stated the nurse providing supervision and orientation to the new nurse should have checked the amount of insulin prepared to ensure the accuracy prior to the new nurse administering the insulin. The DON stated the new nurse realized she administered the wrong dose of insulin almost immediately. The DON stated resident 31's physician was promptly notified and the resident was sent to an acute care hospital. The DON stated the resident returned to the facility a day or two later. A review of resident 31's March 2002, Medication	F 426	The DON reviews the documentation on a daily basis initially, adjusting to Monday thru Friday starting 05/20/2002, then weekly starting 05/28/2002. QA committee will review and make recommendation if the frequency of her reviews will change to ensure accuracy. Medical records staff will review for accuracy on an ongoing basis. Director of Nursing will monitor and report status to the Administrator and the Quality Assurance Committee monthly.	

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	46A066	A. BUILDING ___ B. WING ___	5/10/02

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F 426	Continued From page 12 Administration Record (MAR) was completed on 5/10/02. Per documentation on the MAR, resident 31 received 6 u NPH insulin on 3/5/02 at 7:30 AM. The MAR did not include any documenation that the 7:30 AM dose of NPH was administered incorrectly on 3/5/02. 2. Resident CR1 was admitted to the facility on 8/20/01, with diagnoses including diabetes mellitus type I. A review of the physician orders for resident CR1 was completed on 5/8/02. On 10/20/01, facility staff obtained a physician telephone order to monitor resident CR1's blood sugar before meals and at night. On 10/24/01, the facility nurse received a physician telephone order for CR1 to receive 28 u (units) of NPH (long acting insulin) in the morning, 8 u of NPH insulin in the evening and 9 u of Regular insulin (a faster acting insulin) before meals. The telephone order also documented that the nurse was to hold the regular insulin if the pre-meal blood sugar was less than 130. A review of resident CR1's telephone orders dated 1/9/02 was done on 5/10/02. It revealed that there was an order to change the morning NPH insulin order to 20 U and to call the physician if the blood sugar was less than 130. A review of the nurse's notes for the month of February and March 2002 was done on 5/9/02. It revealed that there were 21 times when resident CR1's blood sugar was less than 130 and the physician was not contacted. On 2/2/02 at 1:00 PM, a nurse documented, "Did report [resident CR1]'s BS [blood sugar] of 90 to [attending physician]. States she does not want to be called [every] time his blood sugar is <	F 426		

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F 426	Continued From page 13 [less than] 130. States will change the order when she is in again...." Following this nursing note entry there were no physician orders to indicate staff were not to notify the physician when resident CR1's blood sugar was less than 130. On 5/10/02 at 2:10 PM, resident CR1's physician was interviewed. The physician confirmed she had ordered that she was to be called by the facility when resident CR1's blood sugars were less than 130 and she had never changed the orders. A review of the MAR (medication administration record) for the months of February and March 2002 was done on 5/9/02. It revealed that there were 23 times when the 9 u of Regular insulin was documented as being given and resident CR1's blood sugar was documented as being less than 130. There were 7 times when the Regular and NPH insulin was documented as given and the blood sugar was documented at less than or equal to 60. The facility's laboratory service, documented low normal blood sugars at 70 and high normal blood sugars at 115. A review of resident CR1's MAR and nurse's notes for the month of February and March 2002 was completed on 5/10/02. Per documentation on the MAR and nurse's notes, the following errors in insulin administration and noncommunication by facility nurse to the physician when the blood sugars were below 130 follow: a. On 2/2/02 at 4:30 PM, resident CR1's blood sugar was 96. It was documented at 5:00 PM, 9 u of Regular insulin and 8 u of NPH insulin was given. There was no documentation in resident CR1's record that the attending physician had been notified as orders requested. b. On 2/3/02 at 4:30 PM, resident CR1's blood sugar was 54. It was documented at 5:00 PM, 9 u of	F 426		

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F 426	Continued From page 14 Regular insulin and 8 u of NPH insulin was given. There was no documentation in resident CR1's record that the attending physician had been notified as orders requested. c. On 2/4/02 at 6:00 AM, resident CR1's blood sugar was 102. It was documented at 7:30 AM, 9 u of Regular insulin and 20 u of NPH insulin was given. There was no documentation in resident CR1's record that the attending physician had been notified as orders requested. d. On 2/9/02 at 6:00 AM, resident CR1's blood sugar was 45. It was documented at 7:30 AM, 9 u of Regular insulin and 20 u of NPH insulin was given. There was no documentation in resident CR1's record that the attending physician had been notified as orders requested. e. On 2/9/02 at 11:30 AM, resident CR1's blood sugar was 97. It was documented at 1200 PM, 9 u of Regular insulin was given. There was no documentation in resident CR1's record that the attending physician had been notified as orders requested. f. On 2/9/02 at 4:30 PM, resident CR1's blood sugar was 91. It was documented at 5:00 PM, 9 u of Regular insulin and 8 u of NPH insulin was given. There was no documentation in resident CR1's record that the attending physician had been notified as orders requested. g. On 2/15/02 at 6:00 AM, resident CR1's blood sugar was 129. It was documented at 7:30 AM, 9 u of Regular insulin and 20 u of NPH insulin was given. There was no documentation in resident CR1's record that the attending physician had been notified as orders requested. h. On 2/15/02 at 11:30 AM, resident CR1's blood sugar was 80. It was documented at 12:00 PM, 9 u of Regular insulin was given. There was no documentation in resident CR1's record that the attending physician had been notified as orders	F 426		

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F 426	Continued From page 15 requested. i. On 2/16/02 at 6:00 AM, resident CR1's blood sugar was 87. It was documented at 7:30 AM, 9 u of Regular insulin and 20 u of NPH insulin was given. There was no documentation in resident CR1's record that the attending physician had been notified as orders requested. j. On 2/16/02 at 11:30 AM, resident CR1's blood sugar was 127. It was documented at 12:00 PM, 9 u of Regular insulin was given. There was no documentation in resident CR1's record that the attending physician had been notified as orders requested. k. On 2/16/02 at 4:30 PM, resident CR1's blood sugar was 55. It was documented at 5:00 PM, 9 u of Regular insulin and 8 u of NPH insulin was given. There was no documentation in resident CR1's record that the attending physician had been notified as orders requested. l. On 2/17/02 at 6:00 AM, resident CR1's blood sugar was 118. It was documented at 7:30 AM, 9 u of Regular insulin and 20 u of NPH insulin was given. There was no documentation in resident CR1's record that the attending physician had been notified as orders requested. m. On 2/22/02 at 4:30 PM, resident CR1's blood sugar was 124. It was documented at 5:00 PM, 9 u of Regular insulin and 8 u of NPH insulin was given. There was no documentation in resident CR1's record that the attending physician had been notified as orders requested. n. On 2/23/02 at 4:30 PM, resident CR1's blood sugar was 119. It was documented at 5:00 PM, 9 u of Regular insulin and 8 u of NPH insulin was given. There was no documentation in resident CR1's record that the attending physician had been notified as orders requested. o. On 2/24/02 at 6:00 AM, resident CR1's blood sugar was 128. It was documented at 7:30 AM, 9 u of	F 426		

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F 426	Continued From page 16 Regular insulin and 20 u of NPH insulin was given. There was no documentation in resident CR1's record that the attending physician had been notified as orders requested. p. On 2/24/02 at 4:30 PM, resident CR1's blood sugar was 88. It was documented at 5:00 PM, 9 u of Regular insulin and 8 u of NPH insulin was given. There was no documentation in resident CR1's record that the attending physician had been notified as orders requested. q. On 2/28/02 at 11:30 PM, resident CR1's blood sugar was 78. It was documented at 12:00 PM, 9 u of Regular insulin was given. There was no documentation in resident CR1's record that the attending physician had been notified as orders requested. r. On 3/2/02 at 6:00 AM, resident CR1's blood sugar was 123. It was documented at 7:30 AM, 9 u of Regular insulin and 20 u of NPH insulin was given. There was no documentation in resident CR1's record that the attending physician had been notified as orders requested. s. On 3/2/02 at 4:30 PM, resident CR1's blood sugar was 59. It was documented at 5:00 PM, 9 u of Regular insulin and 8 u of NPH insulin was given. There was no documentation in resident CR1's record that the attending physician had been notified as orders requested. t. On 3/3/02 at 6:00 AM, resident CR1's blood sugar was 50. It was documented at 7:30 AM, 9 u of Regular insulin and 20 u of NPH was given. There was no documentation in resident CR1's record that the attending physician had been notified as orders requested. u. On 3/3/02 at 11:30 AM, resident CR1's blood sugar was 60. It was documented at 12:00 PM, 9 u of regular insulin was given. There was no documentation in resident CR1's record that the attending physician had been notified as orders	F 426		

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F 426	Continued From page 17	F 426		

requested.

3. Resident 35 was admitted to the facility on 1/28/02, with diagnoses of diabetes and status post cerebral vascular accident.

A review of the physician orders for resident 35 was completed on 5/10/02. On 2/01/02, facility staff obtained admission orders from resident 35's physician for the following order: blood glucose check four times per day, Humulin U insulin 68 u subcutaneous every day, Humulin U insulin 12 u every evening, hold insulin if blood sugar less than 130.

On 3/08/02, resident 35's physician ordered to discontinue Humulin U insulin 12 u q PM.

On 3/12/02, facility staff obtained a physician's telephone order to change resident 35's Humulin U insulin to 55 u sq q AM and to call physician if blood glucose less than 70 and to hold if less than 130.

On 4/14/02, resident 35's physician ordered the following sliding scale insulin: less than 150 - no sliding scale insulin, 150 to 200 - 2 u Regular insulin, 201 to 250 - 4 u Regular insulin, 251 to 300 - 6 u Regular insulin.

A review of resident 35's MARs for the months of February, March, and April 2002, were completed on 5/10/02. Per documentation on the MAR, the following errors in scheduled Humulin U insulin administration were made in February:

a. 2/01/02 - At 6:30 AM, resident 35's blood glucose level was 56. Per physician's orders, resident 35 should not have received AM insulin but 68 u of insulin was documented as given.

b. 2/02/02 - At 4:30 AM, resident 35's blood

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F 426	Continued From page 18 glucose level was 86. Per physician's orders, resident 35 should not have received PM insulin but 12 u of insulin was documented as given. c. 2/03/02 - At 6:30 AM, resident 35's blood glucose level was 82. Per physician's orders, resident 35 should not have received AM insulin but 68 u of insulin was documented as given. d. 2/04/02 - At 6:30 AM, resident 35's blood glucose level was 92. Per physician's orders, resident 35 should not have received AM insulin but 68 u of insulin was documented as given. e. 2/05/02 - At 6:30 AM, resident 35's blood glucose level was 86. Per physician's orders, resident 35 should not have received AM insulin but 68 u of insulin was documented as given. f. 2/07/02 - At 6:30 AM, resident 35's blood glucose level was 109. Per physician's orders, resident 35 should not have received AM insulin but 68 u of insulin was documented as given. g. 2/08/02 - At 6:30 AM, resident 35's blood glucose level was 78. Per physician's orders, resident 35 should not have received AM insulin but 68 u of insulin was documented as given. h. 2/08/02 - At 4:30 PM, resident 35's blood glucose level was 89. Per physician's orders, resident 35 should not have received PM insulin but 12 u of insulin was documented as given. i. 2/09/02 - At 6:30 AM, resident 35's blood glucose level was 94. Per physician's orders, resident 35 should not have received AM insulin but 68 u of insulin was documented as given. j. 2/10/02 - At 6:30 AM, resident 35's blood glucose level was 117. Per physician's orders, resident 35 should not have received AM insulin but 68 u of insulin was documented as given. k. 2/15/02 - At 6:30 AM, resident 35's blood glucose level was 111. Per physician's orders, resident 35 should not have received AM insulin but 68 u of insulin was documented as given.	F 426		

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F 426	Continued From page 19 l. 2/16/02 - At 6:30 AM, resident 35's blood glucose level was 70. Per physician's orders, resident 35 should not have received AM insulin but 68 u of insulin was documented as given. m. 2/17/02 - At 6:30 AM, resident 35's blood glucose level was 117. Per physician's orders, resident 35 should not have received AM insulin but 68 u of insulin was documented as given. n. 2/17/02 - At 4:30 PM, resident 35's blood glucose level was 126. Per physician's orders, resident 35 should not have received PM insulin but 12 u of insulin was documented as given. o. 2/21/02 - At 6:30 AM, resident 35's blood glucose level was not documented and 68 u of insulin was documented as given. p. 2/22/02 - At 6:30 AM, resident 35's blood glucose level was 90. Per physician's orders, resident 35 should not have received AM inulin but 68 u of insulin was documented as given. q. 2/22/02 - At 4:30 PM, resident 35's blood glucose level was 118. Per physician's orders, resident 35 should not have received PM insulin but 12 u of insulin was documented as given. r. 2/23/02 - At 6:30 AM, resident 35's blood glucose level was 75. Per physician's orders, resident 35 should not have received AM insulin but 68 u of insulin was documented as given. s. 2/27/02 - At 6:30 AM, resident 35's blood glucose level was 62. Per physician's orders, resident 35 should not have received AM insulin but 68 u of insulin was documented as given. t. 2/28/02 - At 6:30 AM, resident 35's blood glucose level was not documented, nor was her insulin administration documented. u. 2/28/02 - At 4:30 PM, resident 35's blood glucose level was not documented, nor was her insulin administration documented. Per documentation on the MAR, the following errors	F 426		

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F 426	Continued From page 20 in scheduled Humulin U insulin administration were made in March: a. 3/03/02 - At 6:30 AM, resident 35's blood glucose level was 98. Per physician's orders, resident 35 should not have received AM insulin but 68 u of insulin was documented as given. b. 3/03/02 - At 4:30 PM, resident 35's blood glucose level was 129. Per physician's orders, resident 35 should not have received PM insulin but 12 u of insulin was documented as given. c. 3/10/02 - At 6:30 AM, resident 35's blood glucose level was 60. Per physician's orders, resident 35 should not have received AM insulin but 68 u of insulin was documented as given. d. 3/22/02 - At 6:30 AM, resident 35's blood glucose level was 85. Per physician's orders, resident 35 should not have received AM insulin but 55 u of insulin was documented as given. e. 3/25/02 - At 6:30 AM, resident 35's blood glucose level was 123. Per physician's orders, resident 35 should not have received AM insulin but 55 u of insulin was documented as given. f. 3/30/02 - At 6:30 AM, resident 35's blood glucose level was 114. Per physician's orders, resident 35 should not have received AM insulin but 55 u of insulin was documented as given. Per documentation on the MAR, the following errors in scheduled Humulin U insulin administration were made in April: a. 4/10/02 - At 6:00 AM, resident 35's blood glucose level was 107. Per physician's orders, resident 35 should not have received AM insulin but 55 u of insulin was documented as given. b. 4/11/02 - At 6:00 AM, resident 35's blood glucose level was 118. Per physician's orders, resident 35 should have not received AM insulin but 55 u of insulin was documented as given. c. 4/12/02 - At 6:00 AM, resident 35's blood	F 426		

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F 426	Continued From page 21 glucose level was 118. Per physician's orders, resident 35 should have not received AM insulin but 55 u of insulin was documented as given. d. 4/14/02 - At 6:00 AM, resident 35's blood glucose level was 117. Per physician's orders, resident 35 should have not received AM insulin but 55 u of insulin was documented as given. e. 4/16/02 - At 6:00 AM, resident 35's blood glucose level was 98. Per physician's orders, resident 35 should have not received AM insulin but 55 u of insulin was documented as given. f. 4/17/02 - At 6:00 AM, resident 35's blood glucose level was 107. Per physician's orders, resident 35 should have not received AM insulin but 55 u of insulin was documented as given. g. 4/22/02 - At 6:00 AM, resident 35's blood glucose level was 128. Per physician's orders, resident 35 should have not received AM insulin but 55 u of insulin was documented as given. Per documentation on the MAR, the following errors in sliding scale insulin administration were made in April: a. 4/16/02 - At 11:30 AM, resident 35's blood glucose level was 187. Per sliding scale, resident 35 should have received 2 u of Regular insulin but no insulin was documented as given. b. 4/16/02 - At 4:30 PM, resident 35's blood glucose level was 208. Per sliding scale, resident 35 should have received 4 u of Regular insulin but 2 u of Regular insulin was documented as given. c. 4/19/02 - At 6:00 AM, resident 35's blood glucose level was 153. Per sliding scale, resident 35 should have received 2 u of Regular insulin but no insulin was documented as given. d. 4/19/02 - At 8:30 PM, resident 35's blood glucose level was 278. Per sliding scale, resident 35 should have received 6 u of Regular insulin but no insulin was documented as given.	F 426		

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F 426	Continued From page 22 e. 4/20/02 - At 11:30 AM, resident 35's blood glucose level was 193. Per sliding scale, resident 35 should have received 2 u of Regular insulin but no insulin was documented as given. f. 4/20/02 - At 8:30 PM, resident 35's blood glucose level was 278. Per sliding scale, resident 35 should have received 6 u of Regular insulin but no insulin was documented as given. g. 4/21/02 - At 6:00 AM, resident 35's blood glucose level was 173. Per sliding scale, resident 35 should have received 2 u of Regular insulin but no insulin was documented as given. h. 4/23/02 - At 6:00 AM, resident 35's blood glucose level was 150. Per sliding scale, resident 35 should have received 2 u of Regular insulin but no insulin was documented as given. i. 4/23/02 - At 11:30 AM, resident 35's blood glucose level was 198. Per sliding scale, resident 35 should have received 2 u of Regular insulin but no insulin was documented as given. j. 4/24/02 - At 6:00 AM, resident 35's blood glucose level was 155. Per sliding scale, resident 35 should have received 2 u of Regular insulin but no insulin was documented as given. k. 4/26/02 - At 8:30 PM, resident 35's blood glucose level was 158. Per sliding scale, resident 35 should have received 2 u of Regular insulin but no insulin was documented as given. l. 4/27/02 - At 6:00 AM, resident 35's blood glucose level was 192. Per sliding scale, resident 35 should have received 2 u of Regular insulin but no insulin was documented as given. m. 4/27/02 - At 4:30 PM, resident 35's blood glucose level was 151. Per sliding scale, resident 35 should have received 2 u of Regular insulin but 4 u of Regular insulin was documented as given. n. 4/27/02 - At 8:30 PM, resident 35's blood glucose level was 187. Per sliding scale, resident 35 should have received 2 u of Regular insulin but no	F 426		

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insulin was documented as given.

o. 4/28/02 - At 6:00 AM, resident 35's blood glucose level was 152. Per sliding scale, resident 35 should have received 2 u of Regular insulin but no insulin was documented as given.

p. 4/28/02 - At 11:30 AM, resident 35's blood glucose level was 182. Per sliding scale, resident 35 should have received 2 u of Regular insulin but no insulin was documented as given.

q. 4/28/02 - At 8:30 PM, resident 35's blood glucose level was 194. Per sliding scale, resident 35 should have received 2 u of Regular insulin but no insulin was documented as given.

4. Resident 7 was admitted to the facility on 1/03/02, with diagnoses of chronic paranoid schizophrenia, diabetes mellitus, hypertension (HTN), dementia, hypoxia and right hip pinning.

A review of physician orders for resident 7 was completed on 5/10/02. On 1/03/02, facility staff obtained admission orders to monitor resident 7's blood glucose before meals and at bedtime with sliding scale Regular insulin. The sliding scale insulin orders established parameters for administering insulin based on resident 7's blood glucose levels. The sliding scale insulin order was as follows: less than 200 - no sliding scale insulin, 201 to 250 - 2 units (u) Regular insulin, 251 to 300 - 4 u Regular insulin, 301 to 350 - 6 u Regular insulin, 351 to 400 - 8 u Regular insulin. The sliding scale insulin order included parameters for facility staff to call the doctor when resident 7's blood glucose level was less than 70 or greater than 400.

On 2/06/02, resident 7's physician changed the glucose monitoring from before meals and bedtime to twice per day.

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F 426	Continued From page 24 On 4/18/02, resident 7's physician gave a telephone order for "10 u of Reg [regular] insulin 1 time only as a result of 441 FBS [fasting blood sugar]". A review of resident 7's MARs for the months of February, March, and April 2002, was completed on 5/10/02. Per documentation on the MAR, the following errors in insulin administration were made in February: a. 2/01/02 - At 6:00 AM, resident 7's blood glucose level was 104. Per sliding scale, resident 7 should not have received any insulin but at 7:30 AM, 6 u of Regular insulin was documented as given. b. 2/01/02 - At 4:30 PM, resident 7's blood glucose level was 108. Per sliding scale, resident 7 should not have received any insulin but 6 u of Regular insulin was documented as given. c. 2/05/02 - At 11:30 AM, resident 7's blood glucose level was 209. Per sliding scale, resident 7 should have received 2 u of Regular insulin but no insulin was documented as given. d. 2/07/02 - At 6:00 AM, resident 7 did not have a blood glucose level documented on the MAR or in the nurse's notes but there was documentation that 2 u of Regular sliding scale insulin was given. e. 2/09/02 - At 6:00 AM, resident 7's blood glucose level was 65. There was no documentation in resident 7's record that the attending physician was notified as orders requested. Per documentation on the MAR, the following errors in sliding scale insulin administration were made in March: a. 3/04/02 - At 5:00 PM, resident 7's blood glucose level was 282. Per sliding scale, resident 7 should have received 4 u of Regular insulin but received 6 u of Regular insulin. b. 3/07/02 - At 6:00 AM, resident 7's blood glucose level was 215. Per sliding scale, resident 7	F 426		

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F 426	Continued From page 25 should have received 2 u of Regular insulin but received 0 units according to the MAR. c. 3/10/02 - At 5:00 PM, resident 7's blood glucose level was 229. Per sliding scale, resident 7 should have received 2 u of Regular insulin but received 0 units according to the MAR. d. 3/11/02 - At 5:00 PM, resident 7's blood glucose level was 253. Per sliding scale, resident 7 should have received 4 u of Regular insulin but no insulin was documented as given. e. 3/13/02 - At 5:00 PM, resident 7's blood glucose level was 203. Per sliding scale, resident 7 should have received 2 u of Regular insulin but received 0 units according to the MAR. f. 3/14/02 - At 5:00 PM, resident 7's blood glucose level was 255. Per sliding scale, resident 7 should have received 4 u of Regular insulin but 2 u of Regular insulin was documented as given. g. 3/20/02 - At 6:00 AM, resident 7's blood glucose level was 211. Per sliding scale, resident 7 should have received 2 u of Regular insulin but no insulin was documented as given. h. 3/23/02 - At 6:00 AM, resident 7's blood glucose level was 219. Per sliding scale, resident 7 should have received 2 u of Regular insulin but no insulin was documented as given. i. 3/24/02 - At 6:00 AM, resident 7's blood glucose level was 209. Per sliding scale, resident 7 should have received 2 u of Regular insulin but no insulin was documented as given. Per documentation on the MAR, the following errors in sliding scale insulin administration were made in April: a. 4/02/02 - At 6:00 AM, resident 7's blood glucose level was 238. Per sliding scale, resident 7 should have received 2 u of Regular insulin but no insulin was documented as given. b. 4/03/02 - At 6:00 AM, resident 7's blood	F 426		

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F 426	Continued From page 26 glucose level was 352. Per sliding scale, resident 7 should have received 8 u of Regular insulin but no insulin was documented as given. c. 4/05/02 - At 5:00 PM, resident 7's blood glucose level was 347. Per sliding scale, resident 7 should have received 6 u of Regular insulin but 8 u of Regular insulin was documented as given. d. 4/06/02 - At 6:00 AM, resident 7's blood glucose level was 262. Per sliding scale, resident 7 should have received 4 u of Regular insulin but no insulin was documented as given. e. 4/07/02 - At 5:00 PM, resident 7's blood glucose level was 275. Per sliding scale, resident 7 should have received 4 u of Regular insulin but no insulin was documented as given. f. 4/17/02 - At 6:00 AM, resident 7's blood glucose level was 288. Per sliding scale, resident 7 should have received 4 u of Regular insulin but no insulin was documented as given. g. 4/24/02 - At 5:00 PM, resident 7's blood glucose level was 403. Per sliding scale, resident 7's attending physician should have been notified. Resident 7's nurse's notes or record did not have documentation of the physician being notified about blood glucose level over 400. Resident 7's MAR reflected that he received 8 u of Regular insulin. h. 4/28/02 - At 5:00 PM, resident 7's blood glucose level was 276. Per sliding scale, resident 7 should have received 4 u of Regular insulin but 2 and 4 u of Regular insulin were documented as given. i. 4/29/02 - At 6:00 AM, resident 7 did not have a blood glucose level documented on the MAR or in the nurse's notes. j. 4/29/02 - At 5:00 PM, resident 7's blood glucose level was 202. Per sliding scale, resident 7 should have received 2 u of Regular insulin but no insulin was documented as given. A review of the February through May 2002, nursing	F 426		

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notes for resident 7 was completed on 5/10/02. The nursing notes did not clarify sliding scale insulin administration for any of the errors identified on the MARs.

5. Resident 2 was admitted to the facility on 7/10/75. Resident 2's diagnoses include diabetes mellitus type II.

A review of physician orders for resident 2 was completed on 5/10/02. On 4/12/01, facility staff obtained a physician telephone order to monitor resident 2's blood glucose level two times a day. On 6/11/01, resident 2's physician prescribed sliding scale Regular insulin orders. The sliding scale insulin orders established parameters for administering insulin based on resident 2's blood glucose levels. The sliding scale insulin order was as follows: less than 200 - no sliding scale insulin, 201 to 250 - 2 u Regular insulin, 251 to 300 - 4 u Regular insulin, 301 to 350 - 6 u Regular insulin, and greater than 350 - 8 u Regular insulin. This sliding scale insulin order did not include parameters to direct staff to call the physician with either a high or low blood glucose level. In addition to sliding scale insulin orders, resident 2 had a physician order to receive 14 u NPH insulin every morning.

A review of resident 2's MAR for the months of February, March, and April 2002, was completed on 5/10/02. Per documentation on the MAR, the following errors in regularly scheduled and sliding scale insulin administration were made in February:

a. 2/19/02 - At 6:00 AM, resident 2's blood glucose level was 213. Per sliding scale, resident 2 should have received 2 u Regular insulin. No sliding scale Regular insulin was documented as given.

b. 2/28/02 - At 6:00 AM, resident 2's blood glucose level was 218. Per sliding scale, resident 2

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should have received 2 u Regular insulin. No sliding scale Regular insulin was documented as given.

c. 2/28/02 - At 7:30 AM, resident 2 was to receive 14 u NPH insulin. Per documentation, resident 2 did not receive this regularly scheduled dose of insulin.

Per documentation on the MAR, the following errors in regularly scheduled and sliding scale insulin administration were made in March:

a. 3/7/02 - At 6:00 AM, resident 2's blood glucose level was 234. Per sliding scale, resident 2 should have received 2 u Regular insulin. No sliding scale Regular insulin was documented as given. However, on 3/6/02 at 7:30 AM, 2 u Regular insulin was documented as given. Resident 2's blood glucose level did not require sliding scale insulin at that time.

b. 3/14/02 - At 7:30 AM, resident 2 was to receive 14 u NPH insulin. Per documentation, resident 2 did not receive this regularly scheduled dose of insulin.

c. 3/18/02 - At 5:00 PM, resident 2's blood glucose level was 268. Per sliding scale, resident 2 should have received 4 u Regular insulin. No sliding scale Regular insulin was documented as given. However, on 3/17/02 at 5:00 PM, 4 u Regular insulin was documented as given. Resident 2's blood glucose level did not require sliding scale insulin at that time.

d. 3/18/02 - At 7:30 AM, resident 2 was to receive 14 u NPH insulin. Per documentation, resident 2 did not receive this regularly scheduled dose of insulin.

e. 3/22/02 - At 5:00 PM, resident 2's blood glucose level was 333. Per sliding scale, resident 2 should have received 6 u Regular insulin. No sliding scale Regular insulin was documented as given.

f. 3/24/02 - At 5:00 PM, resident 2's blood glucose level was 239. Per sliding scale, resident 2 should have received 2 u Regular insulin. No sliding

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scale Regular insulin was documented as given.

g. 3/29/02 - At 5:00 PM, resident 2's blood glucose level was 274. Per sliding scale, resident 2 should have received 4 u Regular insulin. No sliding scale Regular insulin was documented as given.

h. 3/30/02 - At 5:00 PM, resident 2's blood glucose level was 218. Per sliding scale, resident 2 should have received 2 u Regular insulin. No sliding scale Regular insulin was documented as given.

Per documentation on the MAR, the following errors in sliding scale insulin administration were made in April:

a. 4/7/02 - At 5:00 PM, resident 2's blood glucose level was 327. Per sliding scale, resident 2 should have received 6 u Regular insulin. No sliding scale Regular insulin was documented as given.

b. 4/28/02 - At 6:00 AM, resident 2's blood glucose level was 207. Per sliding scale, resident 2 shouldhave received 2 u Regular insulin. No sliding scale Regular insulin was documented as given.

A review of the February through May 2002, nursing notes for resident 2 was completed on 5/10/02. The nursing notes did not clarify sliding scale insulin administration for any of the errors identified on the MAR.

A review of the February through May 2002, physician orders for resident 2 was completed on 5/10/02. The physician orders did not clarify sliding scale insulin administration for any of the errors identified on the MAR.

6. Resident 11 was admitted to the facility on 3/24/00, with the diagnoses of post CVA (cerebral vascular accident), diabetes, sinusitis and schizophrenia.

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A review of physician orders for resident 11 was completed on 5/10/02. February through March of 2002, recertification physician orders directed staff to perform a blood glucose monitoring 2 times per week on Monday and Thursday. On 4/01/01, facility staff obtained a physician's telephone order to check resident 11's blood glucose level every day and administer sliding scale Regular insulin. The sliding scale insulin orders established parameters for administering insulin based on resident 11's blood glucose levels. The sliding scale insulin order was as follows: less than 200 - no sliding scale insulin, 201 to 250 - 2 units (u) Regular insulin, 251 to 300 - 4 u Regular insulin, greater than 300 - 6 u Regular insulin. This sliding scale insulin order did not include parameters to direct staff to call the physician with either a high or low blood glucose level. On 4/14/02, resident 11's attending physician ordered the blood glucose monitoring to increase to two times a day.

A review of resident 11's MARs for the months of February, March, and April 2002, were completed on 5/10/02. Per documentation on the MAR, the following errors in sliding scale insulin administration were made in April:

a. 4/03/02 - At 6:00 AM, resident 11's blood glucose level was 418. Per sliding scale, resident 11 should have received 6 u of Regular insulin but no insulin was documented as given.

b. 4/09/02 - At 6:00 AM, resident 11's blood glucose level was 309. Per sliding scale, resident 11 should have received 6 u of Regular insulin but 0 u was documented as given.

c. 4/10/02 - At 6:00 AM, resident 11's blood glucose level was 315. Per sliding scale, resident 11 should have received 6 u of Regular inulin but 4 u was documented as given.

d. 4/14/02 - At 6:00 AM, resident 11's blood

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F 426	Continued From page 31 glucose level was 290. Per sliding scale, resident 11 should have received 4 u of Regular insulin but 6 u was documented as given. e. 4/18/02 - At 6:00 AM, resident 11's blood glucose level was 274. Per sliding scale, resident 11 should have received 4 u of Regular insulin but no insulin was documented as given. f. 4/23/02 - At 6:00 AM, resident 11's blood glucose level was 213. Per sliding scale, resident 11 should have received 2 u of Regular insulin but no insulin was documented as given. g. 4/25/02 - At 5:00 PM, resident 11's blood glucose level was 328. Per sliding scale, resident 11 should have received 6 u of Regular insulin but no insulin was documented as given. h. 4/30/02 - At 5:00 PM, resident 11's blood glucose level was 283. Per sliding scale, resident 11 should have received 4 u of Regular insulin but 6 u was documented as given. A review of the February through May 2002, nursing notes for resident 11 was completed on 5/10/02. The nursing notes did not clarify sliding scale insulin administration for any of the errors identified on the MARs.	F 426		
F 429 SS=K	483.60(c)(2) PHARMACY SERVICES The pharmacist must report any irregularities to the attending physician and the director of nursing. This REQUIREMENT is not met as evidenced by: Based on review of Medication Administration Records (MAR), consulting pharmacist reports, and an interview with the consulting pharmacist and the Director of Nursing (DON), it was determined that the consulting pharmacist did not identify drug irregularities to the facility's DON and to the attending physician. The irregularities that were not identified	F 429		

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F 429	Continued From page 32 included: 1. Failure to notify the attending physician when directed to do so by insulin orders; 2. Failure to administer regularly scheduled and sliding scale insulin; 3. Failure to administer accurate dosage of regularly scheduled and sliding scale insulin; and, 4. Failure to monitor blood glucose levels prior to administering insulin. Six residents, diagnosed as having diabetes mellitus resided in the facility during the recertification survey ending 5/10/02. Errors in insulin administration occurred with 5 of the six residents plus one additional discharged resident. (Residents 2, 7, 11, 31, 35, and CR1.) Findings include: An interview with the facility's Director of Nursing was held on 5/10/02 at 8:25 AM. The DON stated she did not recall getting information from the consultant pharmacist that there were problems with insulin administration to residents with diabetes mellitus. The DON stated the consultant pharmacist had not been involved in the facility's quality assurance except for his role in the psychotropic drug review committee. The DON was asked to provide the surveyor with copies of the consultant pharmacist's monthly reports since January 2002. The DON provided copies of the January and February 2002, consultant pharmacy reports but stated she did not have the March or April 2002 reports yet. A telephone interview with the consulting registered pharmacist was held on 5/10/02. The pharmacist stated he has spent about five to six hours a month at the facility. He stated the five to six hours a month	F 429	The pharmacist will report any irregularities to the attending physician and the director of nursing. Arrangements have been made with our pharmacy consulting services provider to have our previous pharmacy consultant replaced with a different consultant. The consulting service has assured us that top priority will be given to reviewing medication errors and reporting of such to administration, the medical director and director of nursing. The new consultant has reviewed all of the resident records and has made significant recommendations to be implemented. Director of Nursing will monitor and report discrepancies to the administrator and the Quality Assurance Committee.	5/13/2002

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included chart reviews and attending psychotropic drug review meetings. The pharmacist stated that he had noticed about two to three holes in insulin administration a month. He stated he asked the facility to establish parameters for calling the physician for high and low blood glucose levels two or three times in the past six months.

The surveyor asked the pharmacist if he reviewed each resident's MAR to determine if there appeared to be medication errors. The pharmacist responded by stating, "Trying to read those med [medication] sheets are not the easiest." The pharmacist stated that for residents with diabetes mellitus he generally reviewed laboratory values such as the glycohemoglobin to determine effectiveness of medication therapy.

The surveyor asked the pharmacist if he had been involved in the facility's quality assurance to provide guidance in adressing medication administration errors. The pharmacist stated he had not been involved in the facility's quality assurance for some time except for his involvement in the psychotropic medication reviews. The surveyor asked to the pharmacist to fax a copy of his March and April 2002 reports to the State Survey Agency.

A review of the consultant pharmacist's reports for the months of January, February, March, and April 2002 was completed. The following "Recommendation/Irregularity" entries regarding insulin administration or monitoring of residents with diabetes mellitus were made:

a. January 29, 2002 - (Resident CR1) "Has order to call doctor if blood glucose is less than 80. Suggest you also add some type of treatment modality for low blood sugars."

b April 28, 2002 - (Resident 2) "On 3/13/ and 3/18 NPH Insulin was not documented on MAR.

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F 429

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Please follow up with nurse to ensure doses given. Also need low-end blood glucose parameters on what to do when blood glucose is too low, etc., and when to hold NPH Insulin."

There were "Recommendation/Irregularity" entries regarding insulin administration or monitoring of residents with diabetes mellitus for the months of February and March 2002.

The medical records of residents 2, 7, 11, 31, 35, and CR1 were reviewed. Each of these residents were diagnosed as having diabetes mellitus and had orders to receive insulin. Additionally, per documentation, there were errors in insulin administration for each of these residents. The Drug Regimen Review for each of these residents, between January and April 2002, was reviewed. The consultant pharmacist made the following comments regarding insulin administration or blood glucose monitoring:

a. Resident 2 - January, no comments. February, "poor compliance [with] diet." March, "[Glycohemoglobin] 8.4 2 missed NPH 3/14 3/18." April, no comments.

b. Resident 7 - No comments for January, February, March, or April.

c. Resident 11 - January, no comments. February, no comments. March, no comments. April, "Glucophage ? ... Glucose 291."

d. Resident 31 - January, no comments. February, no comments. March, "Glipizide 1/2 hr ac [one half hour before meals]." April, no comments.

e. Resident 35 - January, no comments. February, no comments. March, "Follow BS [blood sugar]..." April, no comments.

f. Resident CR1 (Note: this resident was discharged on 3/6/02.) - January, "Treatment of low BS [blood sugar] call MD? Suggest immediate treatment." February, no comments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A066	A. BUILDING ______ B. WING ______	5/10/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLA CARE CENTER	3094 SOUTH STATE STREET SALT LAKE CITY, UT 84165

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 429	Continued From page 35 Between January and April 2002, the consultant pharmacist identified three irregularities on the facility's monthly report regarding insulin administration and diabetes mellitus monitoring. Per documentation in residents' medical records, during this same time period, 118 errors occurred. Refer to Tag F-426.	F 429		
F 441 SS=D	483.65(a)(1)-(3) INFECTION CONTROL The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observations, it was determined that for 2 non-sampled residents, the facility staff did not provide meal assistance to residents in a manner that would reduce the risk of cross contamination. (Residents 3 and 28.) Findings include: 1. On 5/7/02, from 7:35 AM to 7:52 AM, an observation was made of nurse aide 1 providing assistance to residents 3 and 28, during the breakfast meal. Both residents were observed to require extensive assistance from staff with dining. Nurse aide 1 was observed to wear the same pair of gloves throughout the observation. During the 17 minute observation, nurse aide 1 was observed to provide assistance in a manner that would increase the risk of cross-contaminate between residents 3 and 28, 16 times. Examples of potential cross-contamination included: Nurse aide 1 was observed to wipe the	F 441	Staff has been in-serviced on the proper manner of feeding the will reduce the risk of cross contamination for residents 3, 28. Facility staff will provide meal assistance to residents in a manner that would reduce the risk of cross contamination. All appropriate staff has been in-serviced on proper technique to avoid cross contamination. Staff has been supplied with hand sanitizer solution to use when assisting multiple residents with feeding assistance. Director of Nursing will monitor and report status to the Administrator and the Quality Assurance Committee	5/16/2002

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F 441	Continued From page 36 mouths of both resident 3 and 28 and then proceded to handle each resident's utensils. Nurse aide 1 was also observed to cover the mouth of resident 28 when he coughed. Nurse aide 1 then continued to provide assistance to resident 3 by handling the resident's utensils with the contaminated hand. Nurse aide 1 was also observed to pick up resident 28's drinking glasses by the rim, in the area that the resident would be placing his mouth. 2. On 5/7/02, from 12:36 PM to 1:06 PM, an observation was made of nurse aide 2 providing assistance to resident 3 and 28, during the noon meal. Nurse aide 2 was observed to wear the same pair of gloves throughout the observation. During the 30 minute observation, nurse aide 2 was observed to provide assistance in a manner that would increase the risk of cross-contamination between residents 3 and 28, 21 times. Examples of potential cross-contamination included: Nurse aide 2 was observed to wipe the mouths of both resident 3 and 28 and then proceded to handle each resident's utensils. Nurse aide 1 was also observed to cover the mouth of resident 28 when he coughed. Nurse aide 2 then continued to provide assistance to resident 3 by handling the resident's utensils with the contaminated hand. Nurse aide 2 was also observed to pick up resident 28's drinking glasses by the rim, in the area that the resident would be placing his mouth.	F 441		
F 521 SS=K	483.75(o)(2)&(3) ADMINISTRATION 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.	F 521		

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F 521	Continued From page 37 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. This REQUIREMENT is not met as evidenced by: Based on interviews and review of facility records, it was determined that the facility's quality assessment and assurance committee failed to develop and fully implement appropriate plans of action to correct identified quality deficiencies. Specifically, between January and April 2002, per documentation in residents' medical records, 118 errors in insulin administration occurred. The types of errors included: 1. Failure to notify the attending physician when directed to do so by insulin orders; 2. Failure to administer regularly scheduled and sliding scale insulin; 3. Failure to administer accurate dosage of regularly scheduled and sliding scale insulin; and, 4. Failure to monitor blood glucose levels prior to administering insulin. Six residents, diagnosed as having diabetes mellitus resided in the facility during the recertification survey ending 5/10/02. Errors in insulin administration occurred with 5 of the six residents plus one additional discharged resident. (Residents 2, 7, 11, 31, 35, and CR1.) Findings include: An interview with the Director of Nursing (DON) was held on 5/9/02 at 2:45 PM. The surveyor asked the DON if the facility's quality assessment and assurance committee had identified a problem with insulin administration. The DON stated that she had been aware there had been some problems with insulin	F 521	The Quality Assurance Committee is comprised of the Administrator, Medical Director, Director of Nursing, Ownership representative, Office Manager, Social Service Worker and Activities Director. The committee has met numerous times since May 10, 2002. We have reviewed the new policies put in place to assure the issues constituting immediate jeopardy have been resolved. The QA Committee will meet weekly until the facility is in substantial compliance, then monthly thereafter. The Medical Director will meet with the committee quarterly. All members of the Quality Assurance Committee received in-service training as indicated in the DPOC. The Administrator will monitor and report status to the Quality Assurance Committee	5/13/2002

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NAME OF PROVIDER OR SUPPLIER: **FRIENDSHIP VILLA CARE CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE: **3094 SOUTH STATE STREET SALT LAKE CITY, UT 84165**		

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F 521	Continued From page 38 administration but that she believed the problem had improved since last fall. The DON approximated the time frame that she became aware of the problem as October 2001. The surveyor asked the DON what corrective measures were put in place to address the errors in insulin administration. The DON stated between October 2001 and February 2002, she had assigned a two different nurses to review the Medication Administration Records (MAR) for errors in blood glucose monitoring and insulin administration. The DON stated these two nurses were not assigned that task at the same time, but rather one nurse for a few months and the other nurse the remaineder of the time. The DON stated in February 2002, she assigned one nurse to review the MARs for errors in blood glucose monitoring and insulin administration. The DON stated that each of the nurses she assigned the review of MARs worked on Friday nights and that the expectation was that the nurse would review the previous weeks MARs and report to the DON on the following Monday. The DON stated the assigned nurse would leave a copy of the questionable MAR in the DON's mail box with the highlighted error. The DON stated she then used the information to counsel the nurse who made the error. The DON stated that since October 2001, she has had to counsel most of the licensed nursing staff. The surveyor asked the DON if she documented the counseling, to which the DON stated, sometimes she did and sometimes she did not. The surveyor asked the DON if any other quality improvement measures had been implemented to ensure that insulin administration errors did not continue. The DON stated she was not aware of any other quality improvement measures in place to address the problem.	F 521		

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F 521	Continued From page 39	F 521		

The DON provided the surveyor copies of monthly calendars labeled as monthly summaries. The DON provided a copy of the November and December 2001, as well as the February, March, April, and May 2002, monthly summaries. Beginning in November 2001, there was documentation on the monthly summaries that "QA" (quality assurance) or checking of the blood glucose levels had been done. This documentation was present for most of the weeks on either a Friday, Saturday, or Sunday. This monthly summary listed only items to be monitored but did not include a summary of findings resulting from the monitoring.

A telephone interview was held with the facility's Medical Director on 5/10/02. The Medical Director stated she had been made aware of an incident with resident 31, in which the resident received 60 units (u) of NPH insulin instead of the ordered 6 u NPH insulin. The Medical Director also stated she was aware of an incident with resident CR1, in which the resident had a low blood glucose level and was unresponsive and that the nurse on duty failed to respond with appropriate interventions. The Medical Director stated she had not been informed by any member of the facility's quality assessment and assurance committee that there had been mulitple errors in insulin administration for residents with diabetes mellitus. The Medical Director stated she did not attend the facility's quality assessment and assurance meetings but rather the committee members contacted her and discussed the issues identifed in the meetings.

The facility's quality assessment and assurance committee failed to put action plans in place to correct errors in insulin administration.
Refer to Tag F-426.

Policy

Change of Condition Reporting to Physician and Tracking

Purpose

To ensure any resident who experiences a change of condition is recognized immediately, reported to the physician, treated accordingly and the change of condition is reported to management personnel so proper tracking for quality assurance purposes can be maintained.

Procedure

1. The nurse or DON will notify the resident's attending physician if there has been:
   a. An accident, injury, incident or injury of unknown origin:
   b. A reaction to medication:
   c. A significant change in the resident's physical/emotional/mental condition:
   d. A need to transfer the resident to a hospital:
   e. A discharge without proper medical authority (AMA):
   f. Repeated refusal of medication:
   g. A medication error has occured:

2. The nurse or DON will notify the family, next of kin, designee or sponsor if there has been a significant change in medical/mental condition of any of the above in number 1 have occurred.

3. The nurse will record the events in the resident's permanent chart.

4. The nurse will inform the on-coming shift of any changes of condition that may be occuring so continuity of care may be maintained.

5. The DON will ascertain if the change of condition warrants a "significant change in status assessment" for MDS purposes.